

48-59-45 1B

FUNERAL DIRECTOR: IMPORTANT

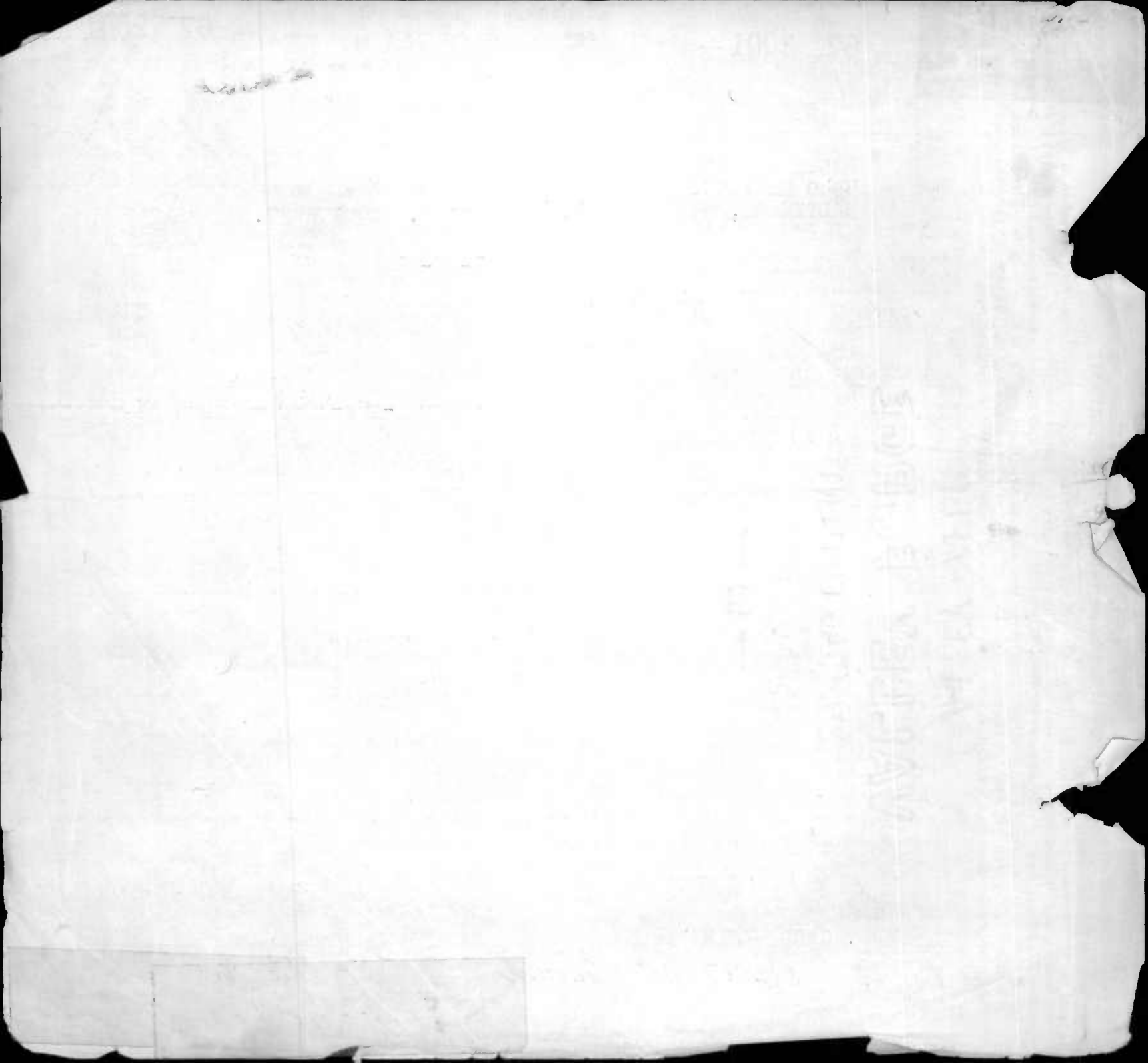
This certificate must be approved by the chief medical examiner or his assistant if death occurred in hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 2001

| | | | |
|--|---------------|--|------------------------------------|
| BIRTH NO. 67 2001 | | M.E. CASE NO. 67 2001 | |
| 1. NAME OF DECEASED (Type or Print) Williams, Stella | | 2. DATE AND HOUR OF DEATH 2/26/67 11:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1002 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 731 N. ASQUITH ST. #21202 | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 3-27-91 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | 10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT | 9. AGE (In years last birthday) 75 |
| 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT #21224 | | ADDRESS RECORDS #BCH-4940 EASTERN AVENUE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Aspiration pneumonia | | CAUSE OF DEATH (A) Myocardial infarction (B) Generalized ASCVD (C) | |
| 19A. DATE OF OPERATION 12/14/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 1/27 19 67 to 2/26 19 67, that (H) (we) last saw the deceased alive on 2/26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Carl Winterstein | | 23B. DATE SIGNED 2/26/67 | |
| 23C. PHYSICIAN'S NAME (Type) DR. CARL WINTERSTEIN | | 23D. ADDRESS Balto. City Hosp. Balto. Ind. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/2/67 | |
| 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn | | 24D. LOCATION Balto. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967 | | 25B. NAME OF REGISTRAR Robert E. Fairbank | |
| 25C. FUNERAL DIRECTOR Joseph S. Rogers | | ADDRESS 1304 N. Central St | |



THE BODY OF F. WILLIAMS WAS RELEASED ON APPROVAL BY D. CORRIGAN OF THE OFFICE OF MEDICAL EXAMINERS. FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|-----------|--|-------------------------|--|--------------------------------|
| BIRTH NO. 67 2002 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2002 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Frederick Douglass Williams | | 2. DATE AND HOUR OF DEATH 2.26.67 | | 12:37PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2665 PENNSYLVANIA AVE. | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 6-9-08 | 9. AGE (In years last birthday) 58 | 10. If Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Handler | | 10B. KIND OF BUSINESS OR INDUSTRY U.S. Post Office | | 11. BIRTHPLACE (State or foreign country) Buie North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JOHN Williams | | 14. MOTHER'S MAIDEN NAME FRANCES McNeal | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II | | 16. SOCIAL SECURITY NO. 216-18-9526 | | 17. INFORMANT ADDRESS Dorothy O. Williams-2665 Pennsylvania Ave. | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hepatic Coma INTERVAL BETWEEN ONSET AND DEATH 8 days | | CAUSE OF DEATH Laenec's Cirrhosis 8-10 yr | | DISEASE OR CONDITION CAUSING DEATH chronic alcoholism | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2.8.67 to 2.26.67 | | 19 | | 19 | |
| that (I) (we) last saw the deceased alive on 2.26.67 | | 19 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE Robert M. Winslow | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2.26.67 | |
| 23C. PHYSICIAN'S NAME (Type) Robert. M. Winslow | | M.D. 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/67 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery | |
| 24D. LOCATION (City, town, or county) Baltimore Maryland | | (State) Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967 | | 25B. NAME OF REGISTRAR Robert E. Carby, M.D. | | 25C. FUNERAL DIRECTOR Nutter Funeral Home -3035 W. North Ave. | |

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67 2003

BALTIMORE CITY HEALTH DEPARTMENT

67 2003

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James T. THOMAS

2. DATE AND HOUR PRONOUNCED DEAD

February 25, 1967 4:30 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1035 Homewood Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1035 Homewood Avenue N. A. 88-0111

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

7/29/1935

9. AGE (In years
last birthday)

30 31

If Under 1 Yr. Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

WELDER (UNEMPLOYED)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MORGANTON, N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

DAIMMIE JOE THOMAS

14. MOTHER'S MAIDEN NAME

ERA THOMPSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

KOREAN WAR

16. SOCIAL
SECURITY NO.

17. INFORMANT

FRED AVERY 2534 GREEN MOUNT AVE

18. E981X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Gunshot wound of head
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

21

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1035 Homewood Avenue (Kitchen)

21D. TIME OF INJURY
(APPROX.)

2-25-67

4:15 P.

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

Shot by assailant

10-01

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

February 26, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

REMOVED

23B. DATE

2/28/67

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

MORGANTON, N.C.

24A. DATE REC'D BY HEALTH DEPT.

FEB 28 1967

24B. NAME OF REGISTRAR

Robert E. Springate

24C. FUNERAL DIRECTOR

ELLIOTT FUNERAL HOME

ADDRESS

N 8531 49 6 7 0 0 0 N 28 N. CAROLINE ST.

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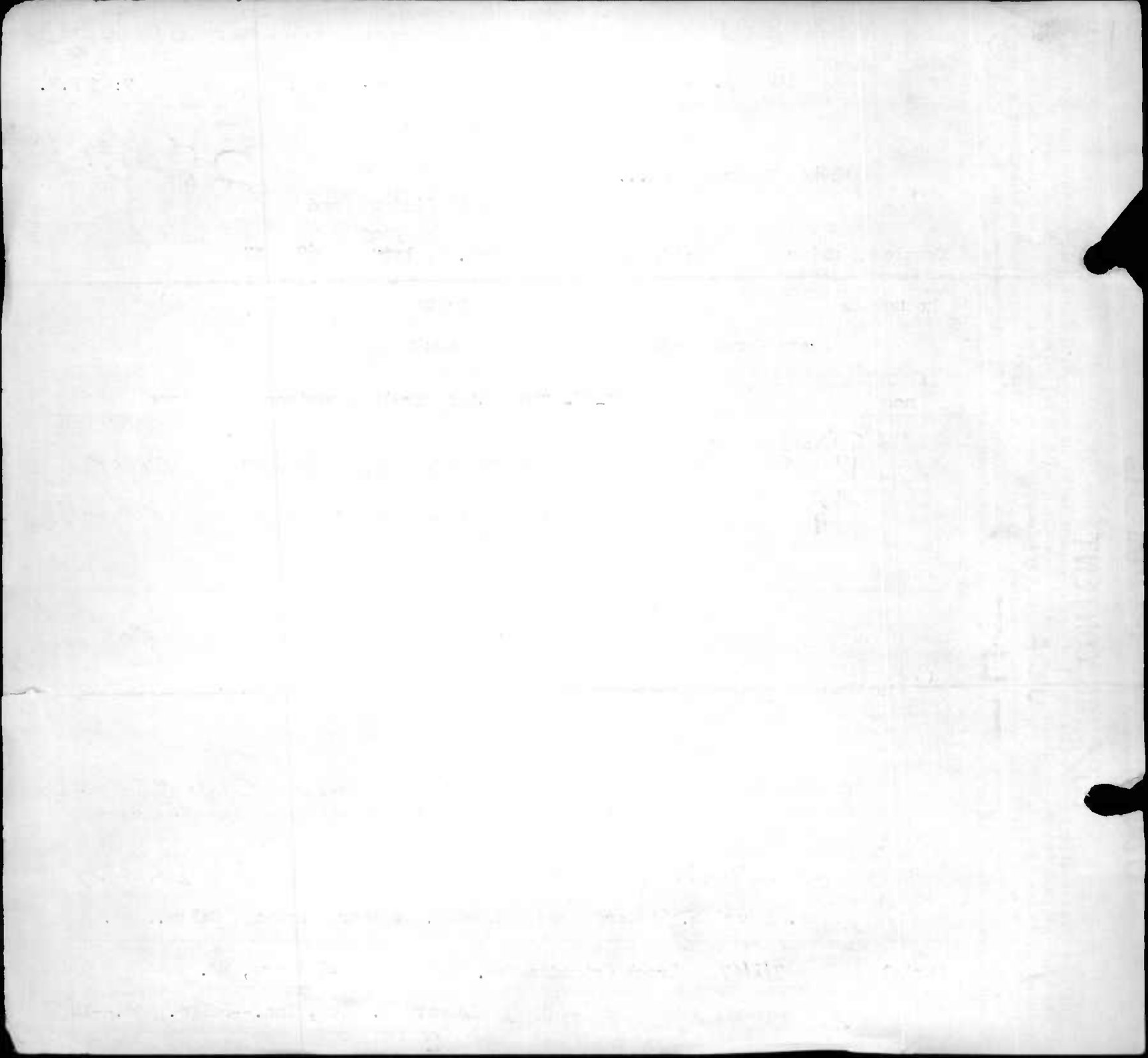
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FUNERAL DIRECTOR: IMPORTANT

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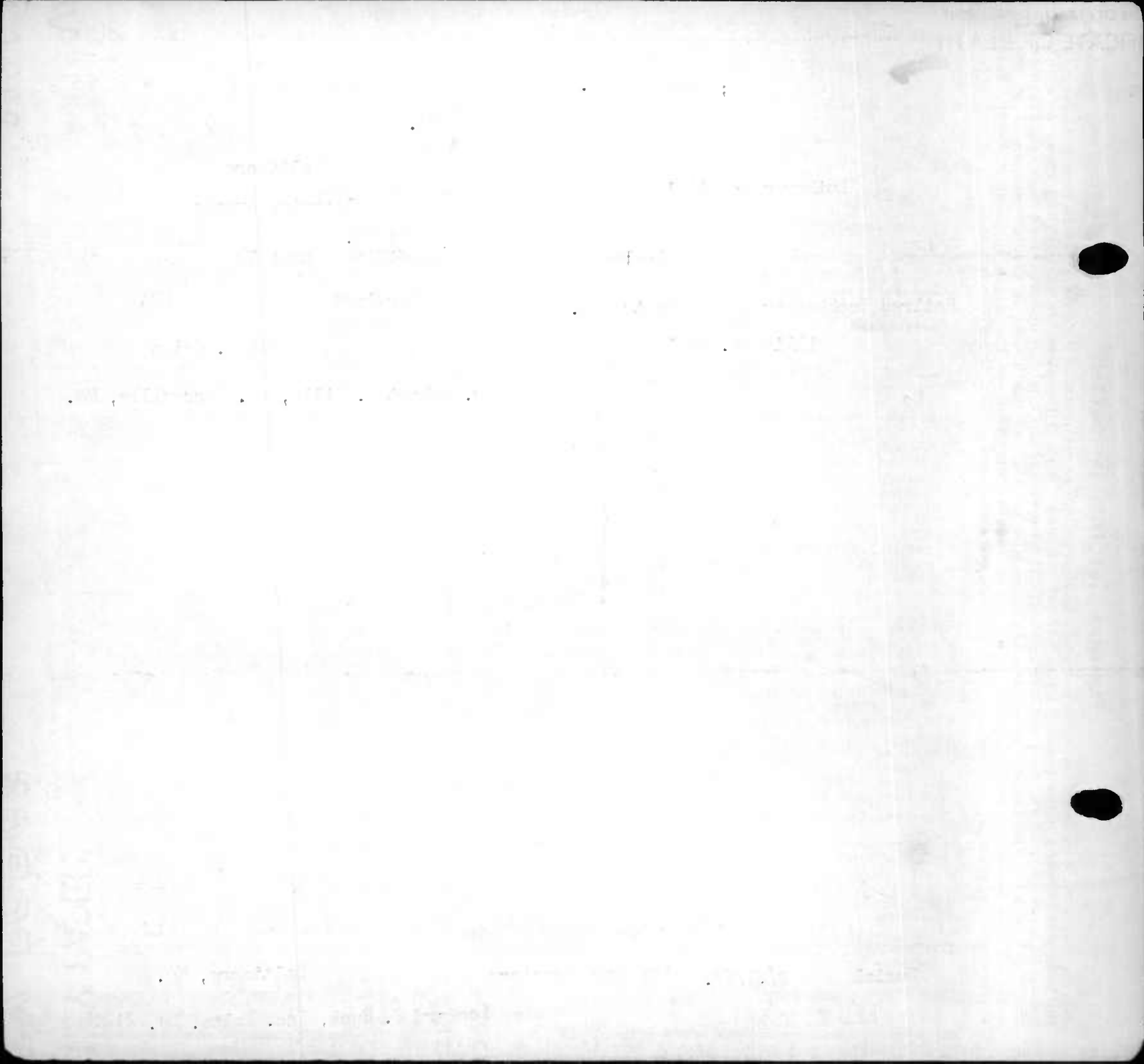
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|--|------------------|---|--|--|---|
| BIRTH NO. 67 2004 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2004 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) DIANE K. AUGERINOS | | 2. DATE AND HOUR OF DEATH Feb. 25, 1967 7:45 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 4946 Lindsay Road...29 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) 4946 Baltimore D. STREET ADDRESS (If rural, give location) 4946 Lindsay Road | | | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 1898 Jan. 7, 1900 | 9. AGE (In years last birthday) 69 67 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Greece | |
| 13. FATHER'S NAME Steve Karageorgis | | 14. MOTHER'S MAIDEN NAME Marcia | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 220-48-8379 | | 17. INFORMANT ADDRESS Miss Marcia Augerinos same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 170X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Metastatic Carcinomatosis DUE TO (B) Carcinoma rt. breast DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 year 18 months | |
| MEDICAL CERTIFICATION II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/18 1962 to 2/25 1967 that (I) (we) last saw the deceased alive on 2/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Israel S. Zinberg | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2/27/67 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Israel S. Zinberg | | 23D. ADDRESS M.D. 4000 W. Northern Parkway, Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/1/67 | | 24C. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cem. | |
| 24D. LOCATION Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967 | | 25B. NAME OF REGISTRAR R. E. E. E. E. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.--Balto., Md.--14 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2005 | |
| BIRTH NO. 67 2005 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) BOYLE; ELLA B. | | 2. DATE AND HOUR OF DEATH 2-24-1967 6:55 p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-07 | |
| 5. SEX F. 6. RACE W. 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | | 8. DATE OF BIRTH 12-24-1892 9. AGE (In years lost birthday) 74 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bookkeeper | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 10B. KIND OF BUSINESS OR INDUSTRY Theatre Co. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William J. Boyle | | 14. MOTHER'S MAIDEN NAME Sarah H. Geipe | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 17. INFORMANT ADDRESS Mr. Robert O. Mills, Jr. Perryville, Md. | |
| 16. SOCIAL SECURITY NO. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA | | CAUSE OF DEATH (A) DUE TO BRONCHOPNEUMONIA (B) DUE TO HYPOCAUDIBS (C) MULTIPLE DEGENERATIVE ULcers | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II Arteriosclerotic heart disease fracture of femoral neck | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-21-67 to 2-24-67 , that (I) (we) last saw the deceased alive on 2-24-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Milos Radojnovic | | 23B. DATE SIGNED 2-24-1967 | |
| 23C. PHYSICIAN'S NAME (Type) MILOS RADOJNOVIC | | 23D. ADDRESS Lutheran Hospital of Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/27/67 | |
| 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. EEB 28 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS | |



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| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2006 | |
|--|-------------------------|--|---|--|---|
| BIRTH NO. 67 2006 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Ferdinand A. Carlson | | | February 28, 1967 12:50 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 Wesley Home 2211 West Rogers Avenue Baltimore, Maryland 21209 | | | A. STATE Maryland | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 2211 West Rogers Avenue 9 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1/22/1876 | 9. AGE (In years last birthday) 91 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Munsell Color Company | | 10B. KIND OF BUSINESS OR INDUSTRY Chemist | 11. BIRTHPLACE (State or foreign country) Sweden | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Carl Carlson | | | 14. MOTHER'S MAIDEN NAME Maja Kojso | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 218-09-4880 | 17. INFORMANT ADDRESS The Wesley Home, Inc. same address | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Anterior sclerotic cardiovascular disease | | | CAUSE OF DEATH Anterior sclerotic cardiovascular disease | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 7 April 1966 to 28 Feb 1967 that (I) (we) last saw the deceased alive on 21 Feb 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John W Barnaby | | | | 23B. DATE SIGNED 28 Feb 67 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN W BARNABY | | | | 23D. ADDRESS 1531 E North Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/1967 | | 24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS Baltimore, Md. | |
| FEB 28 1967 | | | | | |

William Robert Carter
Lancaster

To

at 100 - 1000

27/10/00

Mr. J. B. Tootle

John W. Bannister
John W. Bannister

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2007 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2007 | |
|--|-------------------------|---|--|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Mary E. Bates | | | | 2. DATE AND HOUR OF DEATH February 27, 1967 12⁵⁵ A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Wesley Home 2211 West Rogers Avenue Baltimore, Maryland 21209 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2211 West Rogers Avenue | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 9/6/1800 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months: Days | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME William Norris | | | | |
| 14. MOTHER'S MAIDEN NAME Mary E. Murray | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | | | |
| 16. SOCIAL SECURITY NO. 215-10-1729 | | | 17. INFORMANT ADDRESS The Wesley Home, Inc. same address as above | | | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arterio-sclerotic cardiovascular DUE TO Ischemic ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH 5 days | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 23 October 19 66 to 27 February 19 67 , that (I) (we) last saw the deceased alive on 21 February 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John W. Barnaby | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 27 Feb 67 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN W BARNABY | | | | 23D. ADDRESS M.D. 1531 E North Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/1/1967 | | 24C. NAME OF CEMETERY or CREMATORY Green Mount Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967 | | 25B. NAME OF REGISTRAR John W. Barnaby | | 25C. FUNERAL DIRECTOR Wm. J. 7th Ave & Sons North Ave | | | |

12/21/51

John W. Brown
1231 E. 1st Ave.

Procter & Gamble
The

Chicago

21 February 52

21 February 52

21 Feb 52

1231 E. 1st Ave.

John W. Brown
1231 E. 1st Ave.

48-61-09
FR

1P-36267 2008

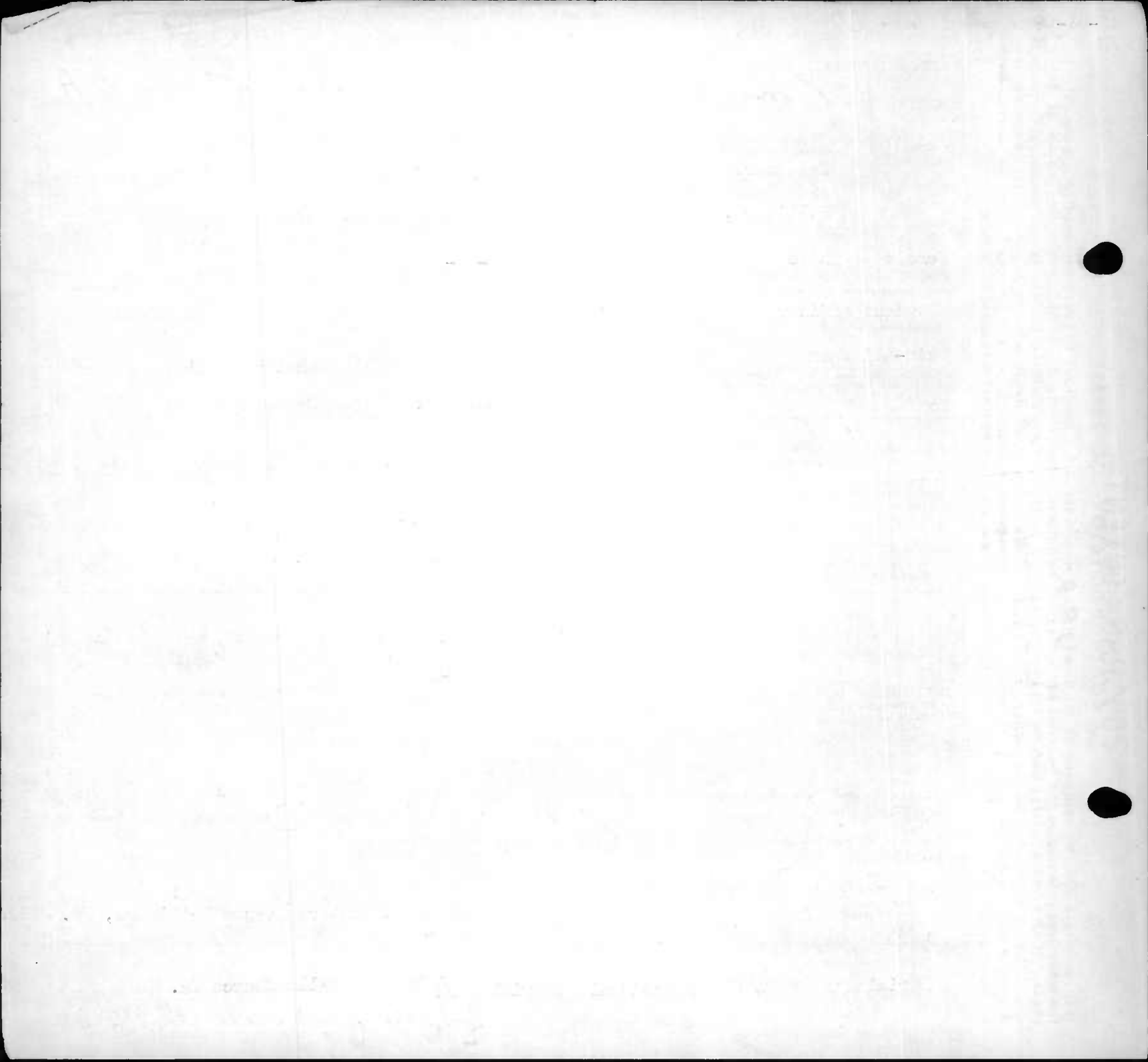
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2008

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|------------------|--|-------------------------------|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| Zenora Patterson | | 2/25/67 5 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 | | (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland | | B. COUNTY Montgomery Co. | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rockville | | RURAL 65-00 | |
| D. STREET ADDRESS (If rural, give location) 13415 Oriental Street | | 20853 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7-15-1924 |
| 9. AGE (In years last birthday) 42 | | 10. CITIZEN OF WHAT COUNTRY? Trinidad | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student officer | | 10B. KIND OF BUSINESS OR INDUSTRY Trinidad Embassy | |
| 11. BIRTHPLACE (State or foreign country) Trinidad | | 12. CITIZEN OF WHAT COUNTRY? Trinidad | |
| 13. FATHER'S NAME Sair-Ali Khan | | 14. MOTHER'S MAIDEN NAME Karen Ramjohn | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224 | | ADDRESS | |
| 18. 204.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) ? Intra cranial hemorrhage (B) Urine myelogenous (C) Leukemia - blastic phase | |
| INTERVAL BETWEEN ONSET AND DEATH 1 day | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Leukemic infiltration of CNS, 6 phlebotomies | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/23 1967 to 2/25 1967, that (I) (we) last saw the deceased alive on 2/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Ashley T. Hase | | 23B. DATE SIGNED 2/25/67 | |
| 23C. PHYSICIAN'S NAME (Type) ASHLEY T. HASE | | 23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. 21224 BALTIMORE CITY HOSPITALS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/28/67 | |
| 24C. NAME OF CEMETERY or CREMATORY National Memorial Park | | 24D. LOCATION Falls Church Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967 | | 25B. NAME OF REGISTRAR N. B. E. E. E. E. E. | |
| 25C. FUNERAL DIRECTOR 201 Hines Co Inc 2901 14th NW WASH. DC | | ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

4-5215

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2009

| | | | | | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. 67 2009 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2009 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Frank John Hanson | | | |
| 2. DATE AND HOUR OF DEATH February 27, 1967 | | M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 3201 Clifton Avenue Baltimore, Maryland 21216 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3201 Clifton Avenue | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH Oct. 18, 1899 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President - Shrinking | | 10B. KIND OF BUSINESS OR INDUSTRY Frank J. Hanson, Inc. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME John J. Hanson | | | |
| 14. MOTHER'S MAIDEN NAME Lillie Pistel | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. Hanson Falter 42 Thornhill Rd. | | | |
| 18. 444 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Sudden acute myocardial failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension | | CAUSE OF DEATH (A) Sudden acute myocardial failure DUE TO (B) Hypertension DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH Sudden 1948 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) did not attended the deceased from September 19 48 to January 31 19 67 , that (I) did not last saw the deceased alive on January 31 19 67 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did not (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Samuel Whitehouse, M.D. | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2/27/67 | |
| 23C. PHYSICIAN'S NAME (Type) Samuel Whitehouse | | 23D. ADDRESS M.D. 3900 North Charles Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/1/1967 | | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Woodlawn, Md. | | 25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR Wm. J. [Signature] | | | |

Baltimore, Md.
with a [Signature]

Handwritten signature

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2010 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2010 | |
|--|---------------------------|--|------------------------------------|--|--|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) WINSTON BURRELL | | 2. DATE AND HOUR OF DEATH 2/25/67 12:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 LINCOLN NURSING HOME | | A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | D. STREET ADDRESS (If rural, give location) 1813 ENTAN VL | | | |
| 5. SEX M | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 1/24/08 | 9. AGE (In years last birthday) 58 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Phillip Burrell | | 14. MOTHER'S MAIDEN NAME Henrietta Burrell | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Cora Burrell 2422 Guilford Ave | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRAL HEMORRHAGE ANTECEDENT CAUSES HYPERTENSIVE CARDIOVASCULAR DISEASE DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/19/66 19 to 2/25/67 19 that (I) (we) last saw the deceased alive on 2/25/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Harris Tennarine M.D. | | | | 23B. DATE SIGNED 2/25/67 | |
| 23C. PHYSICIAN'S NAME (Type) HARRIS TENNARINE | | | | 23D. ADDRESS 930 WHITELOCK ST BALTIMORE MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-28-67 | | 24C. NAME OF CEMETERY or CREMATORY MY Calvary Cem A.A. Co | |
| 24D. LOCATION (City, town, or county) (State) MD | | 25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967 | | 25B. NAME OF REGISTRAR Rayner Sanders 217 E. Preston St | |

Wm. J. Brown
Harris, Tenn.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2011 | |
|--|---------|--|---|--|---|
| BIRTH NO. 67 2011 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) WILLIE G GLOVER | | | Feb. 22, 1967 5:30P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 2623 E. Preston Street Baltimore, Maryland 21213 | | | A. STATE MARYLAND B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 2623 E. Preston Street | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days Hours Min. |
| Male | Colored | Married | 3-13-96 | 70 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Laborer | | Retired | Corncob, N. Carolina | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| David Glover | | | Esther Houston | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| no | | 240-48-2082 | Mrs. Mary Jane Glover 2623 E. Preston St. | | |
| 18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <i>Arteriosclerotic Heart Disease</i> DUE TO <i>& Congestive Heart Failure</i> (B) _____ DUE TO _____ (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH ONE YEAR |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 10 19 67 to Feb. 22 19 67 , that (I) (we) last saw the deceased alive on Feb. 21 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Roland T. Smoot</i> | | | | 23B. DATE SIGNED 2/23/67 | |
| 23C. PHYSICIAN'S NAME (Type) ROLAND T. SMOOT | | | | 23D. ADDRESS 3817 CORLEY RD., BALTO. 15, MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial Transit 2-26-67 | | | | Glenview | |
| | | | | Durham, North Carolina | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967 | | 25B. NAME OF REGISTRAR <i>Robert E. ...</i> | | 25C. FUNERAL DIRECTOR ADDRESS Marshall W. Jones, Jr. 1735 Harford Ave. | |

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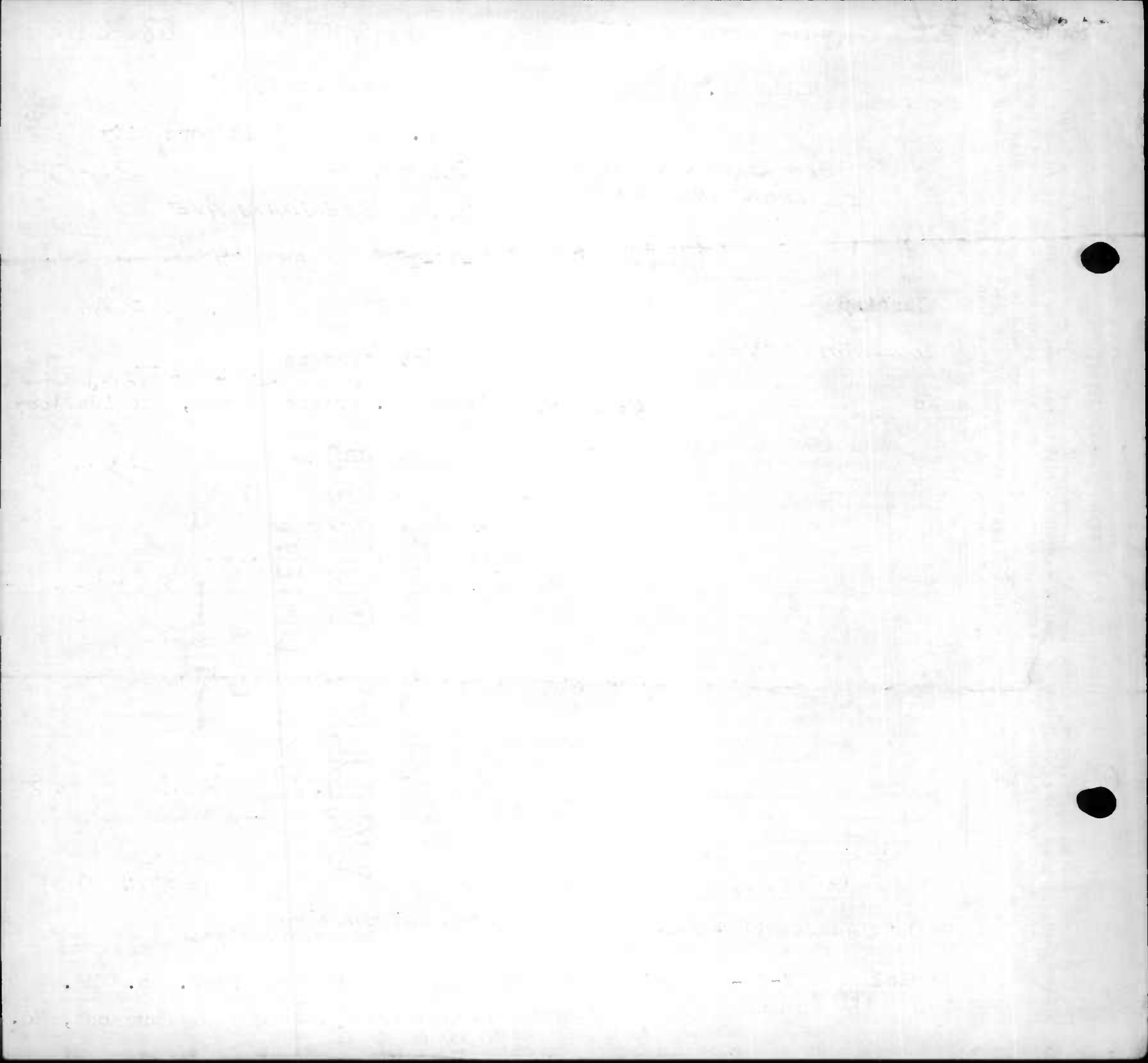
CHIEF

CHIEF

FUNERAL DIRECTOR: IMPORTANT

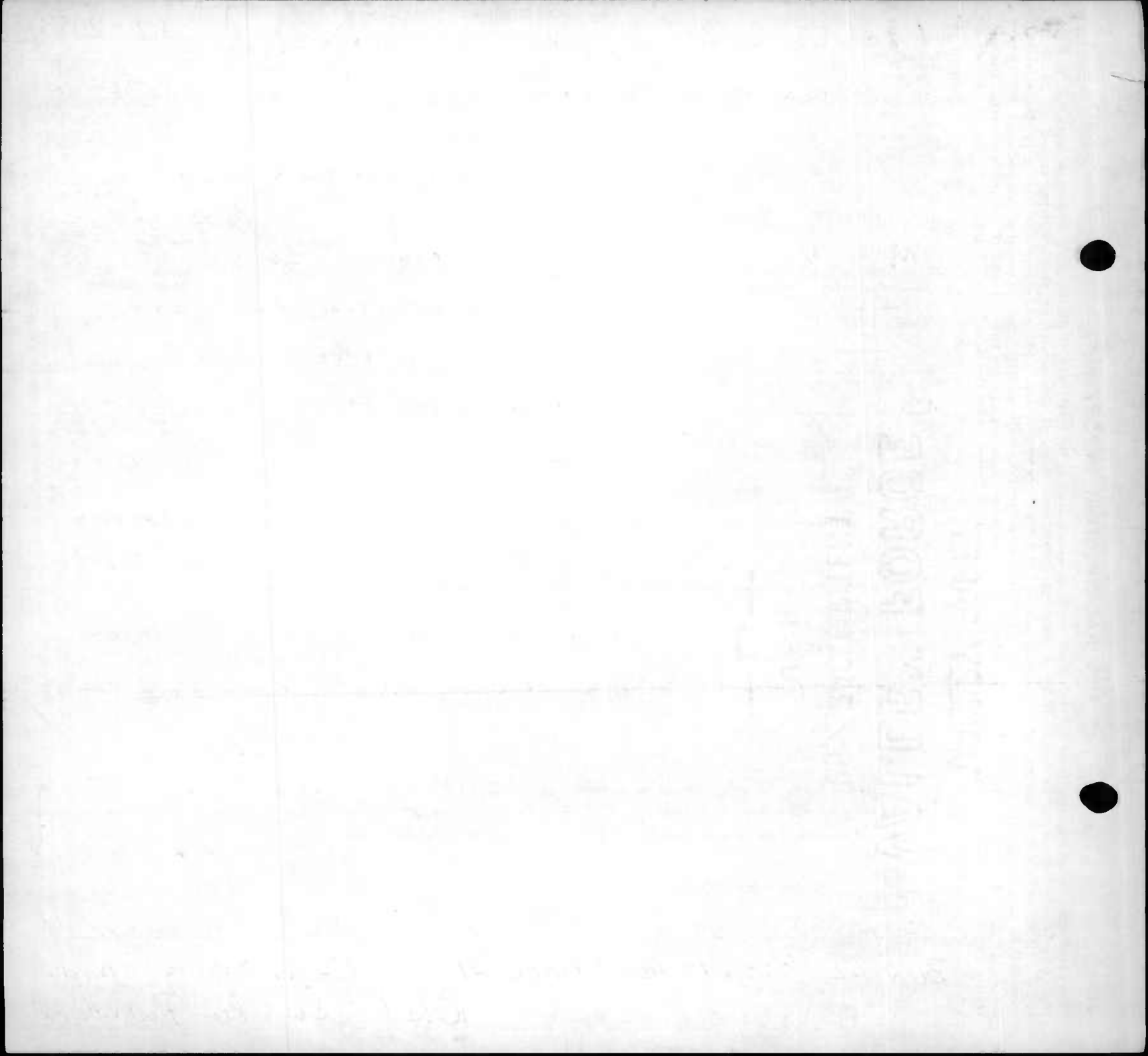
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2012 | |
|---|---|--|--|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 2012 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) NELLE K. REIGHTLER | | 2. DATE AND HOUR OF DEATH FEB 23, 1967 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3018 BRENDAN AVE 00 BALTIMORE MD. 21213 | | A. STATE Md. B. COUNTY Baltimore City | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-03 | | | |
| | | D. STREET ADDRESS (If rural, give location) 3018 BRENDAN AVE | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8-17-1898 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier | | 10B. KIND OF BUSINESS OR INDUSTRY Garage | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME WILLIAM COVER | | 14. MOTHER'S MAIDEN NAME Kate Freeze | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-22-7921 | | 17. INFORMANT ADDRESS 4004 Watson Ave Joseph C. Freeze Tampa, Florida 33609 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.11 | | CAUSE OF DEATH A. Arteriosclerotic cardiovascular disease with congestive failure and pulmonary edema B. Emphysema | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 5 yrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1966 to Feb 1967 , that (I) (we) last saw the deceased alive on Feb 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles M. Kerr | | | | 23B. DATE SIGNED FEB 24, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) DR. CHARLES M. KERR | | | | 23D. ADDRESS 6801 BELAIR ROAD BALTIMORE MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-26-67 | | 24C. NAME of CEMETERY or CREMATORY United Brethren Cem | |
| 24D. LOCATION (City, town, or county) (State) Thurmont Fred. Co. Md. | | | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. FEB 28 1967 | | 25B. NAME OF REGISTRAR Robert E. Galt | | 25C. FUNERAL DIRECTOR ADDRESS Raymond E. Greager Thurmont, Md. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 67 2013 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | | 67 2013 | |
|--|--|---------|--|--|--|----------------|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <u>GORDON MAURICE ANDERSON</u> | | | | | |
| 2. DATE AND HOUR OF DEATH <u>2/21/67</u> <u>15:32</u> <u>A</u> M. | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 UNIVERSITY HOSPITAL</u> | | | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Montgomery Co.</u> | | | | 5. SEX <u>M</u> 6. RACE <u>N</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | | | | | |
| 8. DATE OF BIRTH <u>4/8/40</u> 9. AGE (In years last birthday) <u>26</u> | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | |
| 11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME <u>TILLIE LACY</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. <u>229-50-1742</u> | | | | 17. INFORMANT <u>S.W. TIESENGA M.D.</u> ADDRESS <u>UNIVERSITY HOSP</u> | |
| 18. <u>592X 14002.1</u> CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ASPIRATION</u> | | | | <u>2 hr.</u> | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>UREMIA</u> | | | | <u>4 MONTHS</u> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>PULMONARY TBC</u> | | | | <u>4 MONTHS</u> | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/17</u> 19 <u>67</u> to <u>2/21</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/21/67</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>S.W. Tiesenga</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <u>S. W. TIESENGA</u> M.D. | | | | | | | | 23D. ADDRESS <u>UNIVERSITY HOSPITAL BALTIMORE MD</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | 24B. DATE <u>2/25/67</u> | | | | 24C. NAME OF CEMETERY or CREMATORY <u>Ash Memorial</u> | |
| 24D. LOCATION (City, town, or county) <u>Sandy Spring, Md.</u> | | | | 24E. LOCATION (State) <u>Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 28 1967</u> | | | | 25B. NAME OF REGISTRAR <u>Robert L. Snowden</u> | | | | 25C. FUNERAL DIRECTOR ADDRESS <u>Rockville, Md.</u> | |

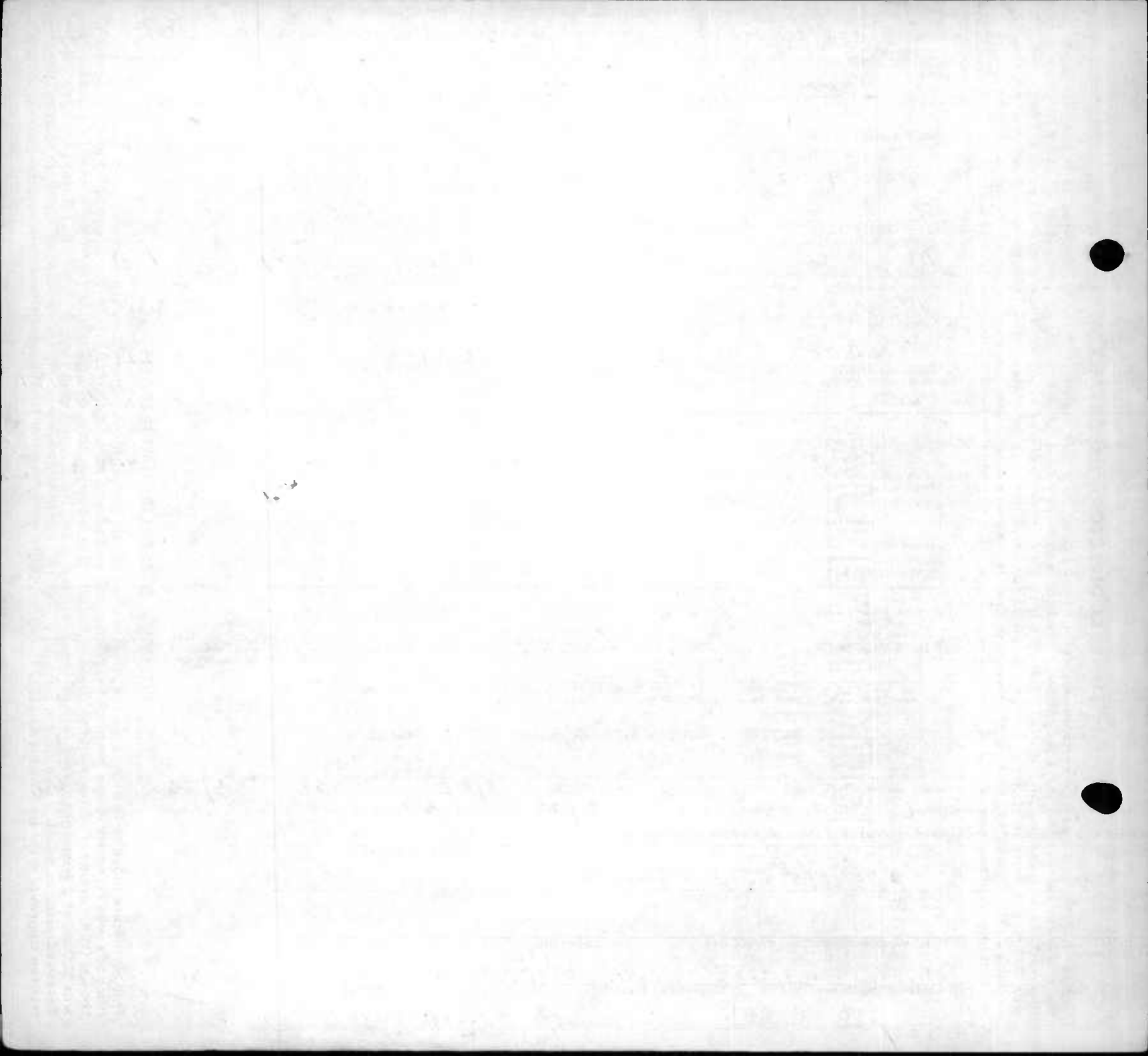


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-126

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2014 | |
|--|--------------|--|-----------------------------|---|--|
| BIRTH NO. 67-03697 2014 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) (BABY BOY) DAVIS, Robert F II | | 2. DATE AND HOUR OF DEATH 2/25/67 10 ²⁰ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY MD. | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL OF BALTIMORE 37 | | D. STREET ADDRESS (If rural, give location) 3976 EDGEHILL AVE. | | 13-08 | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 2/24/67 | 9. AGE (In years last birthday) 1 DAY | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) MARYLAND | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME ROBERT DAVIS | | 14. MOTHER'S MAIDEN NAME CATHERINE SUE PHILLIPS | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Robert F DAVIS 3976 Edgell Ave 21211 | | 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HYALINE MEMBRANE DIS. 1 DAY | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (1) (this hospital) attended the deceased from 2/24 1967 to 2/25 1967, that (1) (we) lost saw the deceased alive on 2/25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE Robert R. Holtzman | | 23B. DATE SIGNED 2/25/67 | | 23C. PHYSICIAN'S NAME (Type) M.D. | |
| 23D. ADDRESS M.D. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-28-67 | |
| 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cem | | 24D. LOCATION (City, town, or county) (State) Trumps Mill Rd Baltimore MD | | 25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967 | |
| 25B. NAME OF REGISTRAR R. R. E. Johnson | | 25C. FUNERAL DIRECTOR Burger Funeral Home 3631 Falls Rd | | 25D. ADDRESS Burger Funeral Home | |



M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

LITTLE, LILLIAN M

2. DATE AND HOUR OF DEATH

2/24/67 12:30 PM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

4940 EASTERN AVENUE, BALTIMORE, MD. 21224

BALTIMORE CITY Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

BOLTON HILL NURSING Home

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

14-01

D. STREET ADDRESS (If rural, give location)

LAFAYETTE & JOHN STREET

5. SEX

Female White

6. RACE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

WIDOW

8. DATE OF BIRTH

7-16-77

9. AGE (In years
last birthday)

89

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry Long

14. MOTHER'S MAIDEN NAME

Hester Franz

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

-

17. INFORMANT

RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224

ADDRESS

18.

4330 + 4904.7

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

cardiac Arrest.

Heart Failure.

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Fracture of hip. (Gus)

19A. DATE OF OPERATION

0 -

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

-

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

-

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

BOLTON HILL NURSING HOME

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY

(APPROX.)

(Month) (Day) (Year) (Hour)

2/22/67

21E. INJURY OCCURRED

While At

Work

Not While

At Work

21F. HOW DID INJURY OCCUR?

Fell down.

22. I certify that (I) (this hospital) attended the deceased from 2/22/67 to 2/24 19 67,

that (I) (we) last saw the deceased alive on 2/24/67 19 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Pablo Trefo Gli M.D.

M.D.

Attending

Phys. ☐

Med.

Director ☐

Staff

Phys. ☒

23B. DATE SIGNED

2/24/67

23C. PHYSICIAN'S
NAME (Type)

PABLO TREFO GLI

23D. ADDRESS

M.D.

4940 Eastern Avenue
BCH Baltimore, Md. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

2-27-67

24C. NAME OF CEMETERY or CREMATORY

Grace Methodist Ch. Cem

24D. LOCATION

(City, town, or county) (State)

Chestnut Ridge, Balto Co Md

25A. DATE RECEIVED BY HEALTH DEPT.

FEB 28 1967

25B. NAME OF REGISTRAR

J. E. ...

25C. FUNERAL DIRECTOR

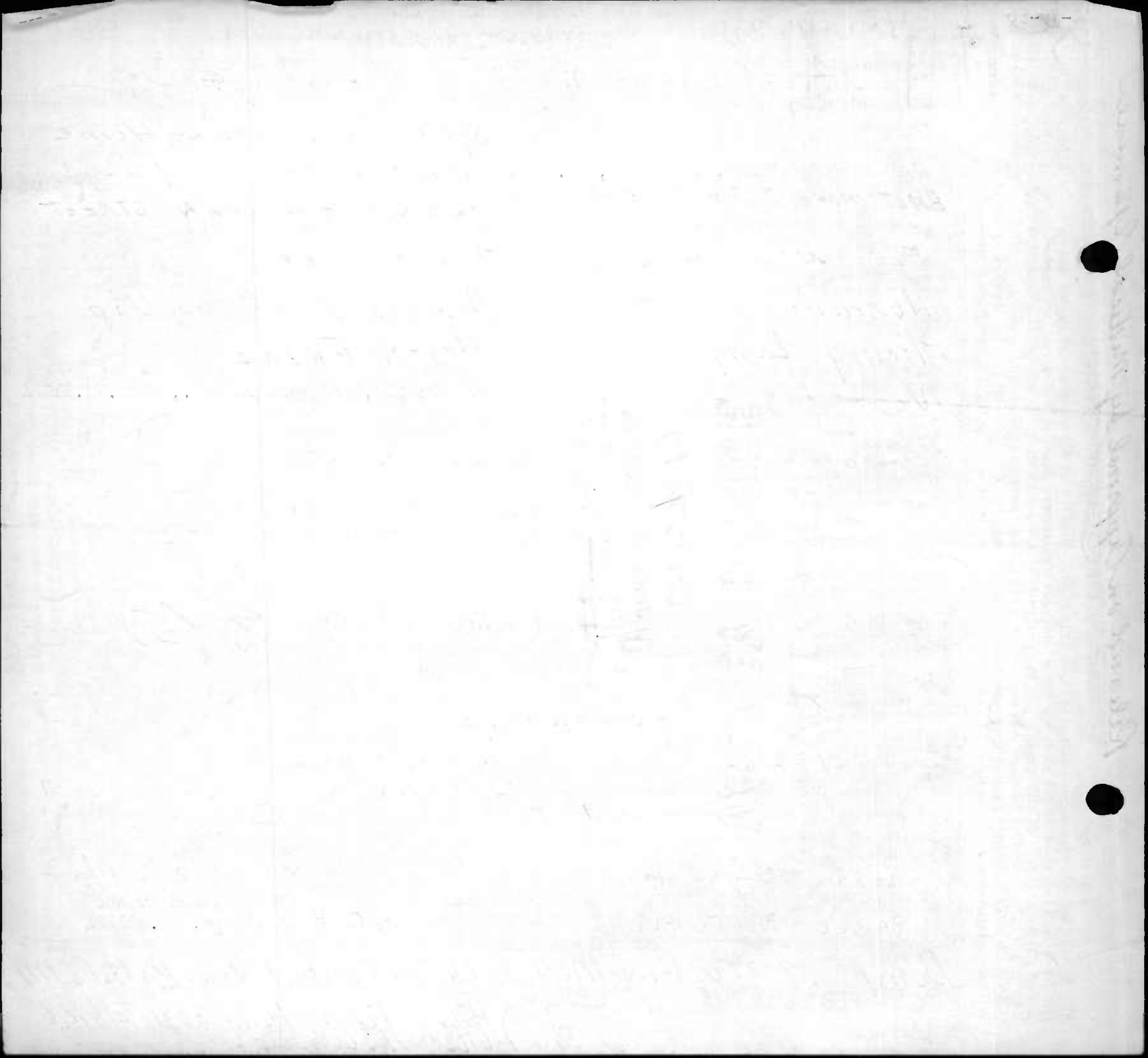
Burgee Funeral Home

ADDRESS

3631 Falls Rd

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Released on Approval by Medical Examiner
FUNERAL DIRECTOR: IMPORTANT



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------|--|------------------|--|---------------------------------|
| 67 2016 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2016 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | |
| | | | | Mary Susan Talbott | |
| 2. DATE AND HOUR OF DEATH | | 2/26/67 5:40 AM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 001103 W 38th ST | | Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1103 W. 38th St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| F | C | | 10/9/84 | 82 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Saleslady - Furniture | | 219 01 6146 | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| John W. Wright | | Elizabeth A. Garrett | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes or no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 21901 6146 | | C. Leroy Talbott 4428 Buena Vista Ave 21211 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 151X I | | Carcinoma of the | | Unknown | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 19 1966 to February 19 1967, that (I) (we) last saw the deceased alive on 2/25/19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Carlton I. Halle | | | | 23B. DATE SIGNED 2/26/67 | |
| 23C. PHYSICIAN'S NAME (Type) Carlton I. Halle | | | | 23D. ADDRESS 6950 Brookmill Rd. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Buried | | 2-1-67 | | Poplar Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. FUNERAL DIRECTOR ADDRESS | | | |
| Baltimore Co Md | | Burger Funeral Home 3631 Falls Pt | | | |
| 25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967 | | 25B. NAME OF REGISTRAR Robert E. Talbott | | 25C. FUNERAL DIRECTOR ADDRESS Burger Funeral Home 3631 Falls Pt | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2017 | |
|--|-------------------------|---|------------------------------------|---|---|
| BIRTH NO. 67 2017 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WILLIAM A. LOATS | | 2. DATE AND HOUR OF DEATH 2-27-67 3:20 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balts Co. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) LANSDOWNE 53-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO. 29, MARYLAND | | D. STREET ADDRESS (If rural, give location) 2431 BRUNSWICK ROAD #27 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8/22/04 | 9. AGE (In years last birthday) 62 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN | | 10B. KIND OF BUSINESS OR INDUSTRY ST. PAUL ST. LODGE #28, 1222 | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME HARRY A. LOATS | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 215-07 6707 | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AV | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 45-1X1 | | CAUSE OF DEATH (A) Hemorrhagic shock DUE TO (B) Ruptured Abdominal aneurysm DUE TO (C) A.S.C.V.D. | | | |
| 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2-26-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED same as above | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Work Not White At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-26- 19 67 to 2-27 19 67 , that (I) (we) last saw the deceased alive on 2-27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M. HATTARKI | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) M. HATTARKI | | 23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-2-67 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cem | |
| 24D. LOCATION (City, town, or county) (State) Woodlawn, Balto Co Md | | 25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS Burgee Funeral Home 3631 Falls Rd | | | |

DATE

7-12-7

TIME 11:10 AM

RECEIVED

OFFICE

UNITED STATES DEPARTMENT OF JUSTICE

FILE NO. 100-100000

DATE OF RECEIPT 7-12-7

BY SA 100-100000

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

BT 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2018 | |
|--|------------------|--|---|--|--|
| BIRTH NO. 67 2018 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) | | |
| | | | MARY T. PARKER | | |
| 2. DATE AND HOUR OF DEATH | | | 2/24/67 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 HOOD NURSING HOME 5213 EDMONDSON AVE. | | | A. STATE Maryland | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 2419 Banger Street | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 11-12-1880 | 9. AGE (In years last birthday) 86 Yrs. | 10. UNDER 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Christian Heffner | | | 14. MOTHER'S MAIDEN NAME Achstedder | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Marie Golden, 2419 Banger Street 21230 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X 17-1038 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO ARTERIO SCLEROTIC DISEASE VASCULAR DISEASE (B) DUE TO PULMONARY EDEMA PNEUMONIA COLON (C) DUE TO | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/1 1967 to 2/24 1967 that (I) (we) lost saw the deceased alive on 2/12 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John Shaw | | | | 23B. DATE SIGNED 2/24/67 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN JOHN SHAW | | | | 23D. ADDRESS 5800 EDMONDSON AVE. BALTIMORE, MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-28-1967 | | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Howard County, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. FEB 28 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229 | | 25D. ADDRESS | | | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2019</u> | |
|---|-------------------|--|--|---|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>67 2019</u> CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Brewer, Frances Louise</u> | | | 2. DATE AND HOUR OF DEATH <u>02-24-67</u> <u>9:25 P. M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>44</u> <u>Union Memorial Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>12-07</u> D. STREET ADDRESS (If rural, give location) <u>138 West 25th Street</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W.</u> | 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>02-24-13</u> | 9. AGE (In years last birthday) <u>54</u> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>American</u> |
| 13. FATHER'S NAME <u>William Hoover</u> | | | 14. MOTHER'S MAIDEN NAME <u>Matida Breeden</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Edward Brewer, 138 W. 25th St., Balto., Md.</u> |
| 18. <u>163 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Ca. of Lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Metastatic Ca to Mediastinum & Spine</u> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>23 Feb. 67</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Biopsy</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>02-14-67</u> to <u>02-24-67</u> , that (I) (we) last saw the deceased alive on <u>02-24-67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Hyong Sok Lee</u> | | | | 23B. DATE SIGNED <u>Feb 24, 67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>HYONG SOK LEE</u> | | 23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2-28-67</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Verona Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Verona, Virginia</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>FEB 28 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave., 21229</u> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--|--|--|--|--|
| 67 2020 | | | | 67 2020 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | |
| | | | | Joseph W. Frazier Jr. FRAZIER JOSEPH | |
| 2. DATE AND HOUR OF DEATH | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| 2-24-67 1400 M. | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3000 University Hospital | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | 5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | |
| Maryland Baltimore | | Male White Married | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| Baltimore 27-38 | | 1-29-19 | | 47 | |
| D. STREET ADDRESS (If rural, give location) | | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 6149 CHINQUAPIN HWY | | None | | | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| USA Pa. | | USA | | JOSEPH FRAZIER | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Sadie DE Haven | | no | | 208-09-56283 | |
| 17. INFORMANT ADDRESS | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | |
| Mrs. Gloria Frazier 6149 Chinquapin Pky. | | (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 782.41 Disease or condition directly leading to death Antecedent causes Diseases or conditions, if any, giving rise to the above cause (A) stating the underlying condition lost. II Other significant conditions contributing to the death but not related to the disease or condition causing it. Colorado failure | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) | |
| 2 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-24-67 1967 to 2-24-67 1967 and that (I) (we) last saw the deceased alive on 2/24/67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| [Signature] | | | | E. Hirsens | |
| 23D. ADDRESS | | 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | |
| O. Hossiford | | Burial | | 2-27-67 | |
| 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | |
| Greenridge Mem. Park | | Fayette Co. Pa. | | FEB 28 1967 | |
| 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | 25D. FUNERAL HOME | |
| Robert E. Jackson | | Howard H. Hubbard Funeral Home | | 24107 Wilkens Ave. | |

500

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-----------|--|-----------------------------------|--|--|--|---|----------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2021 | | | | |
| BIRTH NO. 67 2021 | | M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) SANTAREL MARCO JOSEPH | | 2. DATE AND HOUR OF DEATH 6:00 AM 12/26/67 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 LH. | | | | | A. STATE MARYLAND | | | | |
| (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE LAUREL 19-04 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 51 S. Bruce St- | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 8/9/39 | 9. AGE (In years last birthday) 27 | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? US | | |
| 13. FATHER'S NAME PARSY SANTAREL | | | | | 14. MOTHER'S MAIDEN NAME MARY K PROUL | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Eileen Santarel | | ADDRESS Laurel, Md. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 260 X I | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) DUE TO DIABETES MELLITUS - 20 YRS | | | | |
| ANTECEDENT CAUSES | | | | | (B) DUE TO CONGESTIVE HEART FAILURE - | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (C) MALIGNANT HYPERTENSION | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. RENAL FAILURE | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/27 1967 to 2/26 1967, that (I) (we) last saw the deceased alive on 2/26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Eileen Robinson | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/26/67 | | |
| 23C. PHYSICIAN'S NAME (Type) E. A. ROBINSON | | | | | 23D. ADDRESS 4H | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/1/67 | | 24C. NAME OF CEMETERY or CREMATORY St. Joseph Cemetery | | 24D. LOCATION (City, town, or county) (State) Mt. Pleasant, Penna. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Howard H. Hubbard | | ADDRESS 4107 Wilkens Ave. Baltimore, Maryland 21229 | | | |

10/25/20

11/1/20

11/8/20

11/15/20

11/22/20

11/29/20

12/6/20

12/13/20

12/20/20

12/27/20

1/3/21

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1/17/21

1/24/21

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2/7/21

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2022 | |
|--|--------------------------|--|----------------------------------|--|---|
| BIRTH NO. 67 2022 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 2-28-67 1:00AM | | | |
| 1. NAME OF DECEASED (Type or Print) RYAN, MARY C. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTO. 29, MD. | | A. STATE MD. B. COUNTY Anne Arundel Co. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glen Burnie 52-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) 1010 LANGLEY ROAD 21061 | | | |
| 5. SEX FEMALE | 6. RACE CAUCASION | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 08-16-10 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY Domestic | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME GEORGE VOGTS (DEC'D) | | 14. MOTHER'S MAIDEN NAME PEARL REED (DEO'D) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No NONE | | 16. SOCIAL SECURITY NO. 217 14 5965 | | 17. INFORMANT ADDRESS AVES. #29 | |
| 18. 199-2) I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Recurrent pelvic Ca & Metast. | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (B) 1st no recurrent malignancy | | | |
| ANTECEDENT CAUSES | | (C) | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 24 19 67 to FEBRUARY 28 19 67 , that (I) (we) last saw the deceased alive on FEBRUARY 28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Peter Erbguth | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED FEB. 28, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) DR. PETER ERBGUTH | | 23D. ADDRESS ST. AGNES HOSPITAL: WILKENS & CATON AVES. #29 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-3-67 | | 24C. NAME OF CEMETERY or CREMATORY LORRAINE PARK | |
| 24D. LOCATION (City, town, or county) WOODLAWN, Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Finkbeiner | | 25C. FUNERAL DIRECTOR Geo. L. Schwab, Funeral Home, 2101 Frederick Ave. | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|-------------------------|---|--|--|---|--|---|
| 42-21-64 IV | | A-352 67 2023 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2023 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <i>Adams, Roosevelt</i> | | | |
| 2. DATE AND HOUR OF DEATH <i>2/27/67</i> <i>7:53 A.M.</i> | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 BALTIMORE CITY HOSPITALS</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i> | | | | A. STATE <i>MARYLAND</i> B. COUNTY | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> | | | | D. STREET ADDRESS (If rural, give location) <i>26-12</i> <i>4940 Eastern Avenue, Balto. City Hospitals</i> | | | |
| 5. SEX <i>MALE</i> | 6. RACE <i>NEGRO</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>8/16/14</i> | 9. AGE (In years last birthday) <i>52</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Buyer Bethlehem Steel Co.</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>Floyd Adams</i> | | | 14. MOTHER'S MAIDEN NAME <i>Emma Bell</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES</i> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224</i> | | |
| 18. <i>3-70-11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Probable sepsis</i> (A) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH <i>1-2 da</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <i>Pneumonia & osteomyelitis</i> DUE TO <i>1-2 wks</i> | | | |
| | | | | (C) <i>dysphagia / decubitus ulcers</i> <i>3-5 yrs.</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Multiple Sclerosis</i> | | | | <i>~10 yrs.</i> | | | |
| 19A. DATE OF OPERATION <i>2/11/67</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>bleed</i> | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) <i>no</i> | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11/24</i> 19 <i>64</i> to <i>2/27</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>2/27</i> 19 <i>67</i> and that in (my) <i>OUR</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>We</i> <i>did</i> (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>S.W. Douglas, III</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>2/27/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>S.W. DOUGLAS, III</i> | | | | 23D. ADDRESS <i>Baltimore City Hospitals</i> <i>4940 Eastern Avenue, Balto., Md. 21224</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>March 3/67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>A.A. County Md.</i> | |
| 25A. DATE RECD BY HEALTH DEPT. <i>MAR 1 1967</i> | | 25B. NAME OF REGISTRAR <i>John E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>Milton E. Eickman</i> | | ADDRESS <i>1129 N. Carrollist</i> | |

THE NEW YEAR

Wednesday

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11/24/2

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2/23

2/13

Wm
on

Martha Johnson
for

Photograph / Christmas tree

Memorandum / Christmas

1-5-23
3-2-21

Historical notes

1-5-23

67 2021
18 5898BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2021

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|------------------|--|---|
| BIRTH NO. 67 2021 M.E. CASE NO. 18 5898 | | 2. DATE AND HOUR OF DEATH 2/26/67 110 ³⁰ P.M. | |
| 1. NAME OF DECEASED (Type or Print) Mary Williams | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balt. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hosps 4940 EASTERN AVENUE 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 412 E. 22 nd St | |
| 5. SEX Female | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4/29/05 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY — | 9. AGE (In years last birthday) 61 |
| 13. FATHER'S NAME David Williams | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. — | 11. BIRTHPLACE (State or foreign country) North Carolina |
| 17. INFORMANT RECORDS-BCH-4940 EASTERN AVENUE | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) uremia DUE TO (B) HASCVD DUE TO (C) chronic pyelonephritis | |
| INTERVAL BETWEEN ONSET AND DEATH 22 yrs 22 yrs | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. probable chronic pyelonephritis; gastritis | |
| 19A. DATE OF OPERATION — | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/27/1967 to 2/24/1967, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE A. Silver | | 23B. DATE SIGNED 2/26/67 | |
| 23C. PHYSICIAN'S NAME (Type) DR. ANN SILVER | | 23D. ADDRESS BCH 4940 EASTERN AVENUE 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE MAR 1 1967 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem | | 24D. LOCATION (City, town, or county) (State) A. A. County Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR J. E. Fadden | |
| 25C. FUNERAL DIRECTOR J. E. Fadden | | 25D. ADDRESS 1297 Central | |

AT THE BOW

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|----------------------|---|-------------------------------|--|---|
| BIRTH NO. 67 2025 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2025 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MALINSKI, STELLA (ANASTASIA) | | 2. DATE AND HOUR OF DEATH 2-25-67 845 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND MARYLAND GENERAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21225 (A.A.CO.) D. STREET ADDRESS (If rural, give location) 915 Church St 52-00 | | | |
| 5. SEX FEMALE | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 12-8-1900 | 9. AGE (In years lost birthday) 66 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE |
| 11. BIRTHPLACE (State or foreign country) Austria | | 12. CITIZEN OF WHAT COUNTRY? AUSTRIA | | 13. FATHER'S NAME D. Luchney | |
| 14. MOTHER'S MAIDEN NAME Mary Babee | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 318-01-3243 | |
| 17. INFORMANT PETER P. MALINSKI | | ADDRESS admission record | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) DUE TO Myocardial Infarction 22 hrs Coronary Atherosclerosis - unknown (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2-22-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ABDOMINAL AORTIC ANEURYSM NO | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) none | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none | |
| 21D. TIME OF INJURY (APPROX.) none | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? none | |
| 22. I certify that (If (this hospital) attended the deceased from 2-19-67 to 2-25-67, that (I) (we) last saw the deceased alive on 2-25-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Fred R. Eilber | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2-25-67 | |
| 23C. PHYSICIAN'S NAME (Type) FRED R. EILBER | | M.D. ADDRESS Maryland General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE MAR 1, 1967 | | 24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) ANNE ARUNDEL CO., MD. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Finkowski | |
| 25C. FUNERAL DIRECTOR W. Finkowski | | ADDRESS 2007 EASTERN AVE. | | BALTO. MD. 21231 | |

(H. J. Clark)

1912 (Jan)

1912 (Jan)

No

1912 (Jan)

1912 (Jan)

48-73-79 1B

R-162 67 2026

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2026

FUNERAL DIRECTOR: IMPORTANT

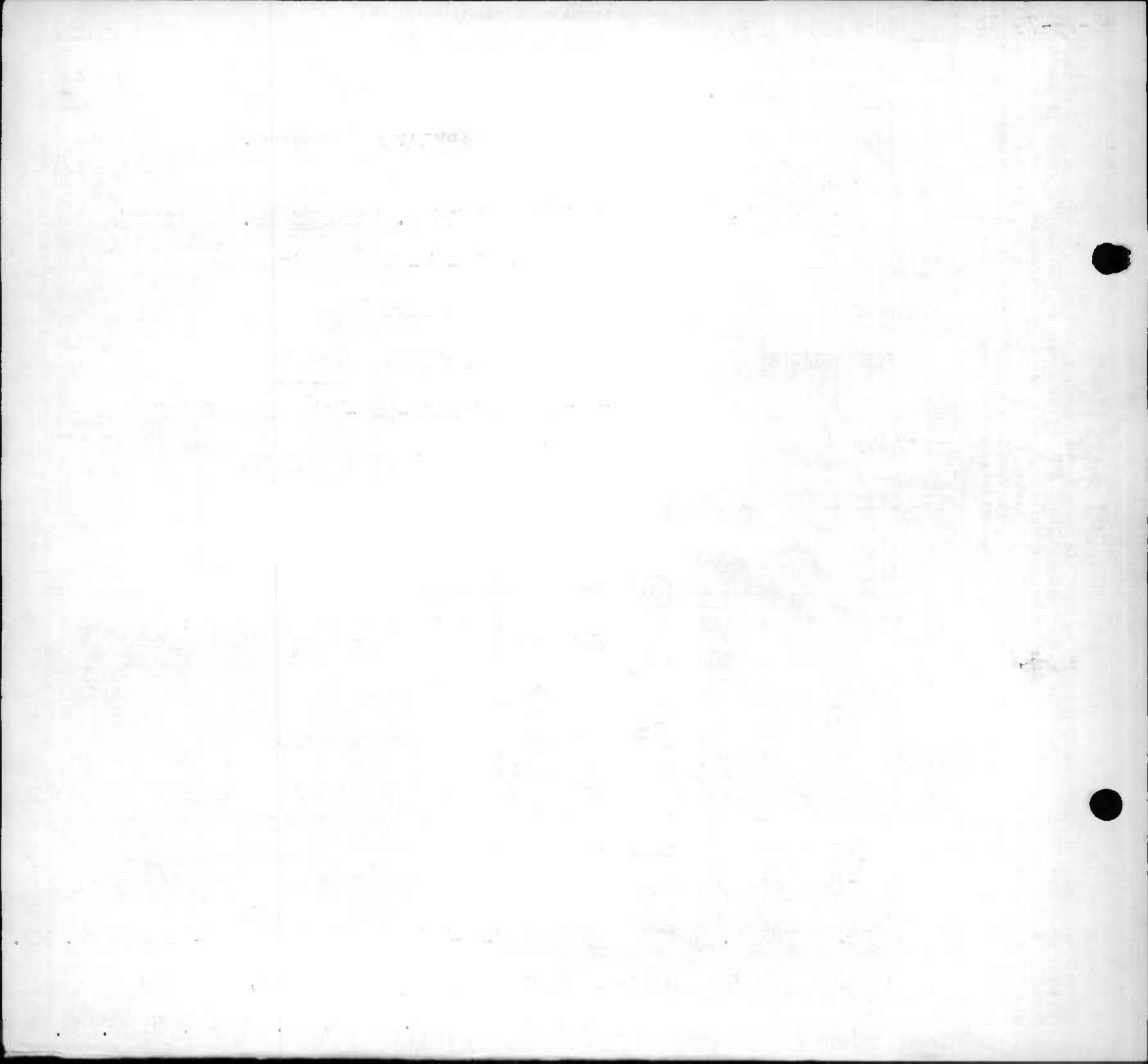
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. R-162 67 2026 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) CHRISTINE M. REHBERGER | | 2. DATE AND HOUR OF DEATH 2/27/67 1124 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3515 E. FAYETTE ST. #21224 | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 12-24-04 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (in years lost birthday) 62 |
| 13. FATHER'S NAME JOHN BLUME | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 16. SOCIAL SECURITY NO. 212-26-0375 | | 14. MOTHER'S MAIDEN NAME DORETHEA Varath | |
| 17. INFORMANT RECORDS-BCH-4940 EASTERN AVENUE | | ADDRESS | |
| 18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH | | | |
| 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. resuscitated 2/21 from 1st arrest | | | |
| 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) YES | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from 2/20 19 67 to 2/27 19 67 , that (I) <u>we</u> last saw the deceased alive on 2/27 19 67 and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> (did not) view the body after death. | | | |
| 23A. SIGNATURE Peter F. Rosen | | 23B. DATE SIGNED 2/27/67 | |
| 23C. PHYSICIAN'S NAME (Type) DR. PETER F. ROSEN | | 23D. ADDRESS 21224 BCH-4940 EASTERN AVENUE-BALTIMORE, MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3/2/67 | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery Baltimore, Maryland | 24D. LOCATION (City, town, or county) (State) |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR John A. Moran, Inc. | 25C. FUNERAL DIRECTOR ADDRESS 3000 E. Balto. St. | |

MAR 1 1967

John A. Moran, Inc.

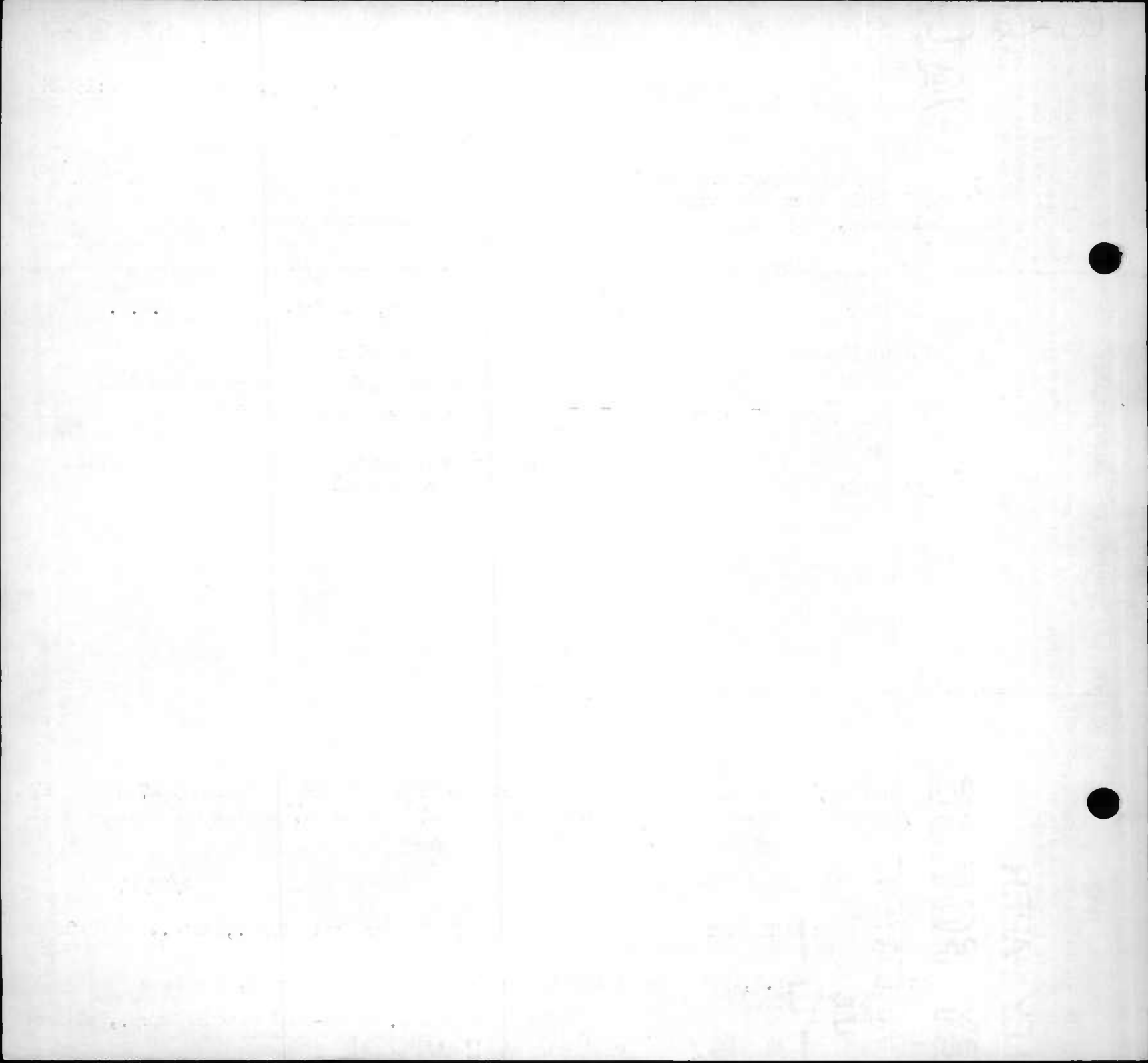
3000 E. Balto. St.



FUNERAL DIRECTOR: IMPORTANT

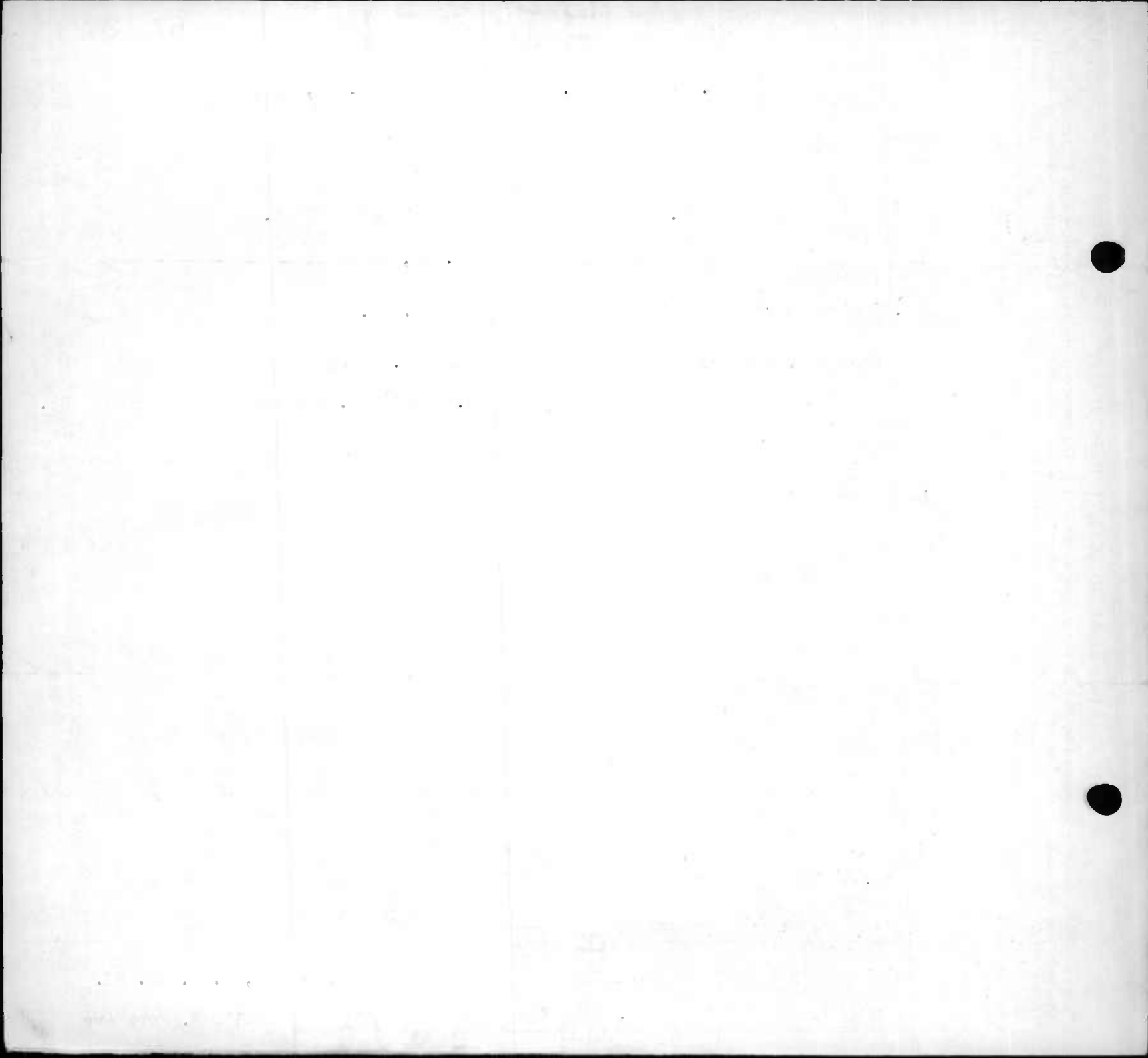
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2027 | |
|---|-------------------------|--|------------------------------------|---|---|
| BIRTH NO. 67 2027 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WHALEN, John Raymond | | 2. DATE AND HOUR OF DEATH February 27, 1967 4:15 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | 24-03 | |
| | | D. STREET ADDRESS (If rural, give location) 1296 Riverside Avenue | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 6/11/14 | 9. AGE (In years last birthday) 52 | <div style="display: flex; justify-content: space-between;"> <div>If Under 1 Yr. Months: Days: Hours: Min.</div> <div>If Under 24 Hrs. Hours: Min.</div> </div> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Transportation | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Thomas Whalen | | 14. MOTHER'S MAIDEN NAME Margaret Tyler | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes 7/17/41-10/24/45 | | 16. SOCIAL SECURITY NO. 220-09-2563 | | 17. INFORMANT ADDRESS 3900 Loch Raven Boulevard VA Hospital Baltimore, Maryland 21218 | |
| 18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Bronchogenic Carcinoma DUE TO Squamous Cell (B) _____ DUE TO _____ (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 4 months | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from October 11th 1966 to February 27th 1967 , that (I) (we) last saw the deceased alive on February 27th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert R. Kent M.D. | | | | 23B. DATE SIGNED 2/27/67 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT KENT | | | | 23D. ADDRESS M.D. VAH 3900 Loch Raven Blvd., Balto., Md 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Mar. 2, 1967 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery Baltimore, Maryland | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Talley, M.D. | |
| 25C. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore | | 25D. ADDRESS | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2028 | |
|---|---|---|---|--|---|
| BIRTH NO. 67 2028 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Joseph E. Sunstrom Jr. | | | 2. DATE AND HOUR OF DEATH Feb. 25, 1967 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 1521 Marshall St. | | | A. STATE Maryland | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 1521 Marshall St. | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Dec. 11, 1910 | 9. AGE (In years last birthday) 56 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Trainmaster | | 10B. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 13. FATHER'S NAME Joseph E. Sunstrom | | | 14. MOTHER'S MAIDEN NAME Emma C. Rowan | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 705 05 3523 | | 17. INFORMANT Mrs. Bernice V. Sunstrom | |
| | | | | ADDRESS 1521 Marshall St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 181.0 I Carcinoma, Bladder | | | CAUSE OF DEATH 20 months | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-14 19 65 to 2-25 19 67 , that (I) (we) last saw the deceased alive on 2-25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Rolando V. Goco | | | | 23B. DATE SIGNED 2-28-67 | |
| 23C. PHYSICIAN'S NAME (Type) Rolando V. Goco | | | | 23D. ADDRESS 707 E. Fort Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3 1 1967 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven | |
| 24D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR Philip E. Farley | | 25C. FUNERAL DIRECTOR Mc Gully | |
| | | | | ADDRESS 130 E. Fort Ave | |



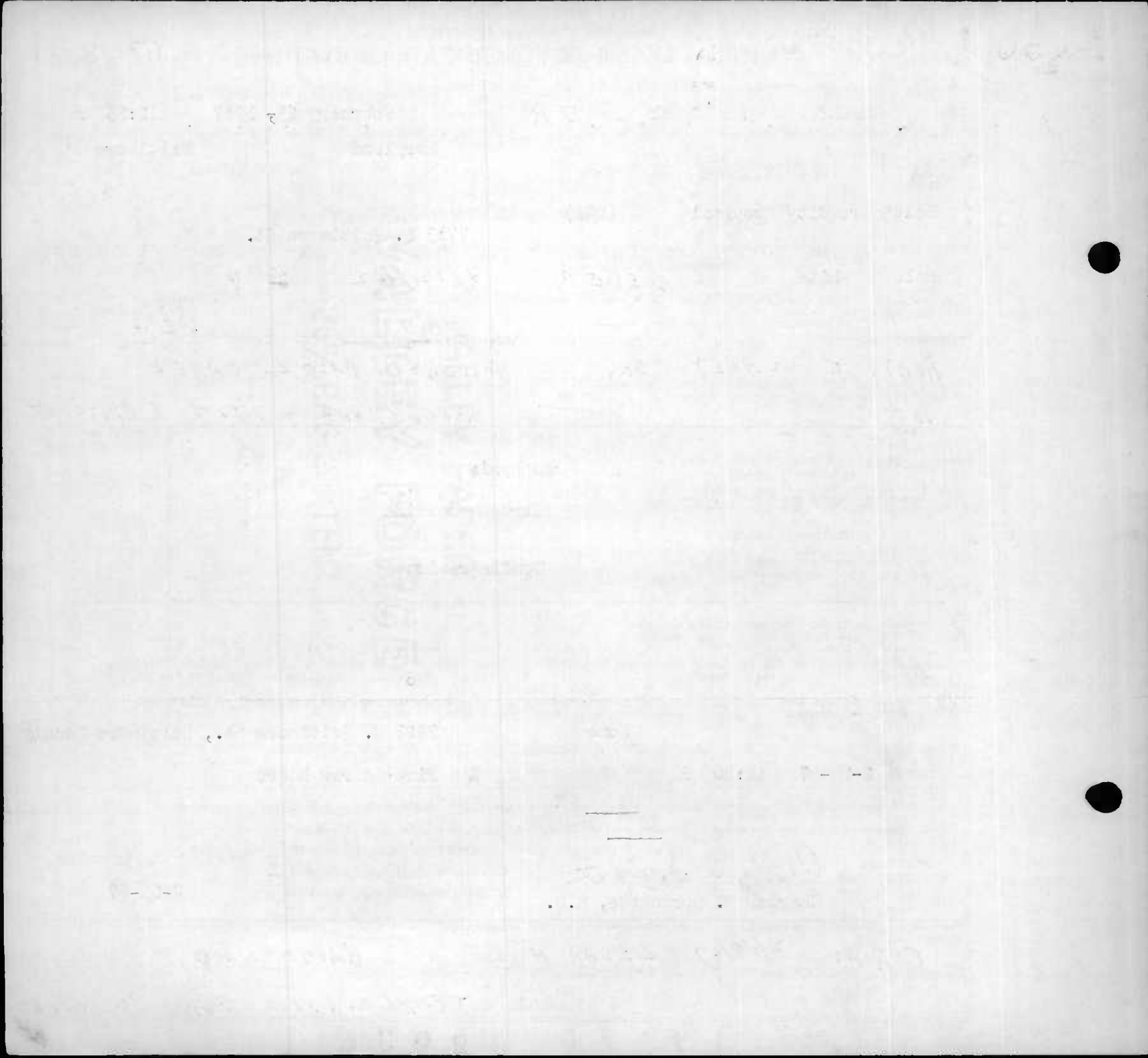
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BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2029

M.E. CASE NO.

| | | | |
|---|-------------------------|---|------------------------------------|
| 1. NAME OF DECEASED (Type or Print) ROBERT CAREY JR | | 2. DATE AND HOUR PRONOUNCED DEAD February 25, 1967 12:25 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital (DOA) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 53-00 D. STREET ADDRESS (If rural, give location) 7713 E. Baltimore St. | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER | 8. DATE OF BIRTH 3/12/62 |
| 9. AGE (In years last birthday) 34 | | 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ROBT. C. CAREY SR. | | 14. MOTHER'S MAIDEN NAME MILDRED BALTZ CAREY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 7727 E. BALTO. ST | |
| 17. INFORMANT R.C. CAREY | | 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Asphyxia ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Carbon monoxide OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Conflagration | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 7727 E. Baltimore St., Baltimore County | | 21D. TIME OF INJURY (APPROX.) 2-24-67 11:40 P | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fire in row house 53-00 | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-25-67 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23B. DATE 2/28/67 | |
| 23C. NAME OF CEMETERY or CREMATORY CEDAR HILL | | 23D. LOCATION (City, town, or county) (State) BALTO MD. | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 24B. NAME OF REGISTRAR Robert E. Farber | |
| 24C. FUNERAL DIRECTOR J.G. CONNELLY SONS | | 24D. ADDRESS 300 MACE | |

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|--|-------------------------|---|-------------------------------------|--|---|
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BONNIE CAREY | | 2. DATE AND HOUR PRONOUNCED DEAD February 25, 1967 12:25 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital (DOA) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 53-00 D. STREET ADDRESS (If rural, give location) 7713 E. Baltimore St. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 10/14/57 | 9. AGE (In years last birthday) 9 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 13. FATHER'S NAME ROBT. C. CAREY SR | | 14. MOTHER'S MAIDEN NAME MILDRED BALTZ CAREY | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT ADDRESS R.C. CAREY 7727 E. BALTO. ST. | |
| 18. 916.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) DUE TO Asphyxia Carbon monoxide (B) DUE TO Conflagration (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2-24-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 7727 E. Baltimore St., Baltimore County | |
| 21D. TIME OF INJURY (APPROX.) 2-24-67 11:40 P | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fire in row house 53-00 | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-25-67 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23B. DATE 2/28/67 | | 23C. NAME OF CEMETERY or CREMATORY CEDAR HILL | |
| 23D. LOCATION (City, town, or county) (State) BALTO. MD. | | 24A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | | |
| 24B. NAME OF REGISTRAR Robert E. Farley | | 24C. FUNERAL DIRECTOR ADDRESS J.D. CONNELLY SONS 300 MACE | | | |

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67 2031
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2031

M.E. CASE NO.

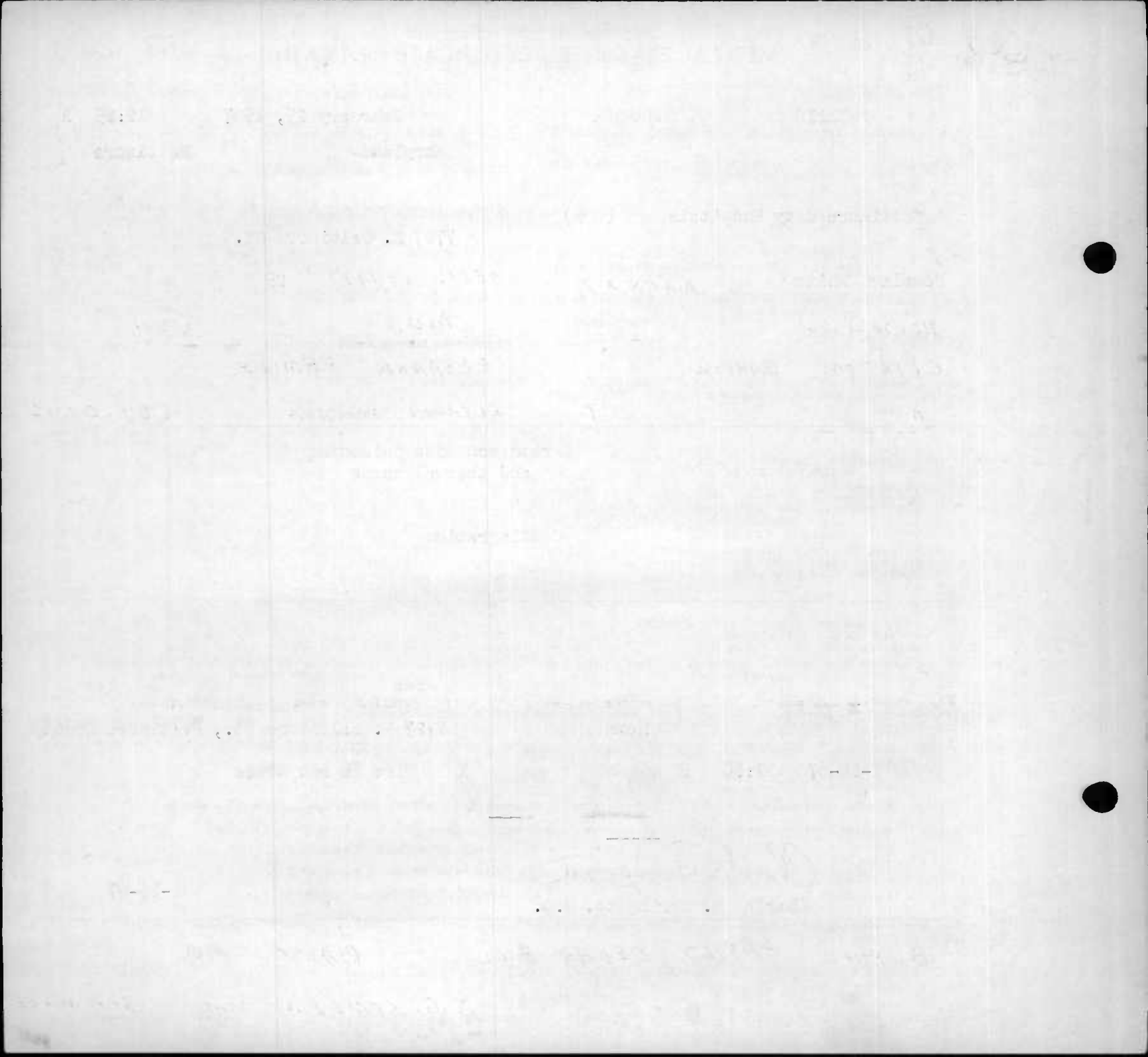
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|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) PHYLLIS SCHRADER | | 2. DATE AND HOUR PRONOUNCED DEAD February 25, 1967 12:25 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals (DOA) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | |
| 5. SEX Female 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | |
| 8. DATE OF BIRTH SEPT. 14, 1937 | | 9. AGE (In years last birthday) 29 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY — | |
| 11. BIRTHPLACE (State or foreign country) MO. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME CLINTON BARLOW | | 14. MOTHER'S MAIDEN NAME ELEANOR ERMINE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. ? | |
| 17. INFORMANT ELEANOR HOMADA | | ADDRESS 284-D 246 | |

| | | |
|--|--|----------------------------------|
| 18. CAUSE OF DEATH Carbon monoxide poisoning and thermal burns | | INTERVAL BETWEEN ONSET AND DEATH |
| (A) DUE TO | | |
| (B) DUE TO Conflagration | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | |
|---|---|--|---|
| 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 7727 E. Baltimore St., Baltimore County | |
| 21D. TIME OF INJURY (APPROX.) 2-24-67 11:40 P | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21F. HOW DID INJURY OCCUR? Fire in two house | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED 2-25-67 | | | |

| | | | |
|--|--|--|---|
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 23B. DATE 2/28/67 | 23C. NAME OF CEMETERY or CREMATORY CEDAR HILL | 23D. LOCATION (City, town, or county) (State) BALTO. MD. |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | 24B. NAME OF REGISTRAR Robert E. Fink | 24C. FUNERAL DIRECTOR J. G. CONNELLY SONS | ADDRESS 300 MACE |

N96858 1967 2031



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

PAMELA

SCHRADER

2. DATE AND HOUR PRONOUNCED DEAD

February 25, 1967

12:25 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)31
99
Baltimore City Hospitals

(DOA)

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

B. COUNTY

Balt. Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

53-00

D. STREET ADDRESS (If rural, give location)

7727 E. Baltimore St.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

12/13/62

9. AGE (In years
last birthday)

4

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

DONALD SCHRADER

14. MOTHER'S MAIDEN NAME

PHYLLIS BARLOW

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

ELEANOR HOMADA

284-0246

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) DUE TO Asphyxia
Carbon monoxide

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) DUE TO
(C) Conflagration

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

7727 E. Baltimore St., Baltimore County

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
2-24-67 11:40 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fire in row house

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

February 27, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

2/28/67

23C. NAME OF CEMETERY or CREMATORY

CEDAR HILL

23D. LOCATION

(City, town, or county)

BALTO. MD

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 1 1967

24B. NAME OF REGISTRAR

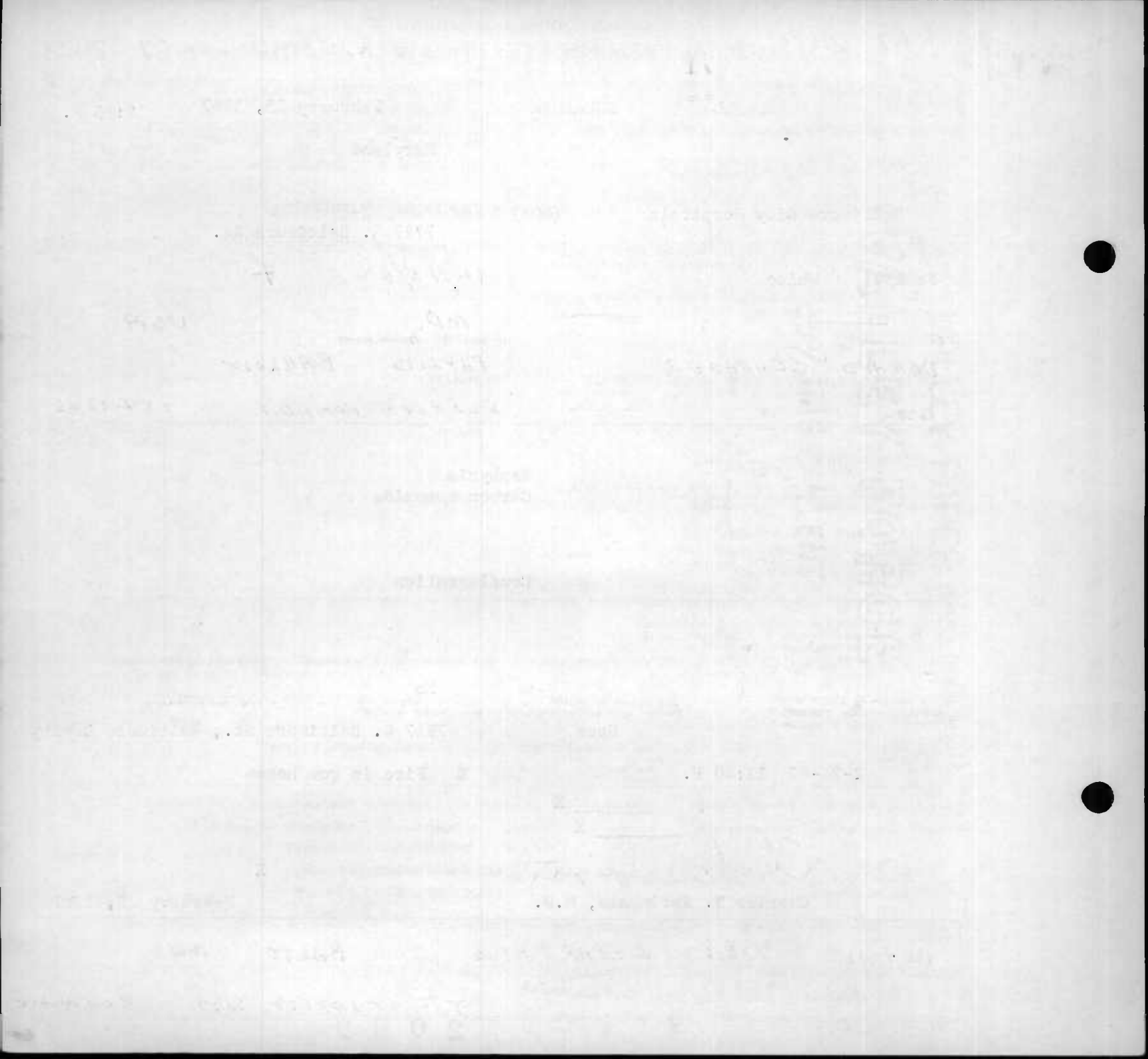
Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

J.G. CONNELLY SONS

ADDRESS

300 MACE



1
S-634BALTIMORE CITY HEALTH DEPARTMENT
BIRTH NO. 67 2033 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2033

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) DONALD SCHRADER 2. DATE AND HOUR PRONOUNCED DEAD February 25, 1967 12:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital (DDA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

EAST POINT 53-00

D. STREET ADDRESS (If rural, give location)

7727 E. Baltimore St.

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

NEVER

8. DATE OF BIRTH

Apr 1, 1958

9. AGE (In years last birthday)

28

If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

DONALD SCHRADER

14. MOTHER'S MAIDEN NAME

PHYLLIS BARLOW

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ELEANOR HOMAOA

ADDRESS

284-0246

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO Asphyxia

Carbon monoxide

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Conflagration

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

7727 E. Baltimore St., Baltimore County

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

2-24-67

11:40 P

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fire in row house

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL SIGNATURE

Charles S. Springate

M.D.

ASSISTANT MEDICAL EXAMINER ☒

2-25-67

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

2/28/67

23C. NAME OF CEMETERY or CREMATORY

CEDAR HILL

23D. LOCATION

(City, town, or county)

BALTO. MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 1 1967

24B. NAME OF REGISTRAR

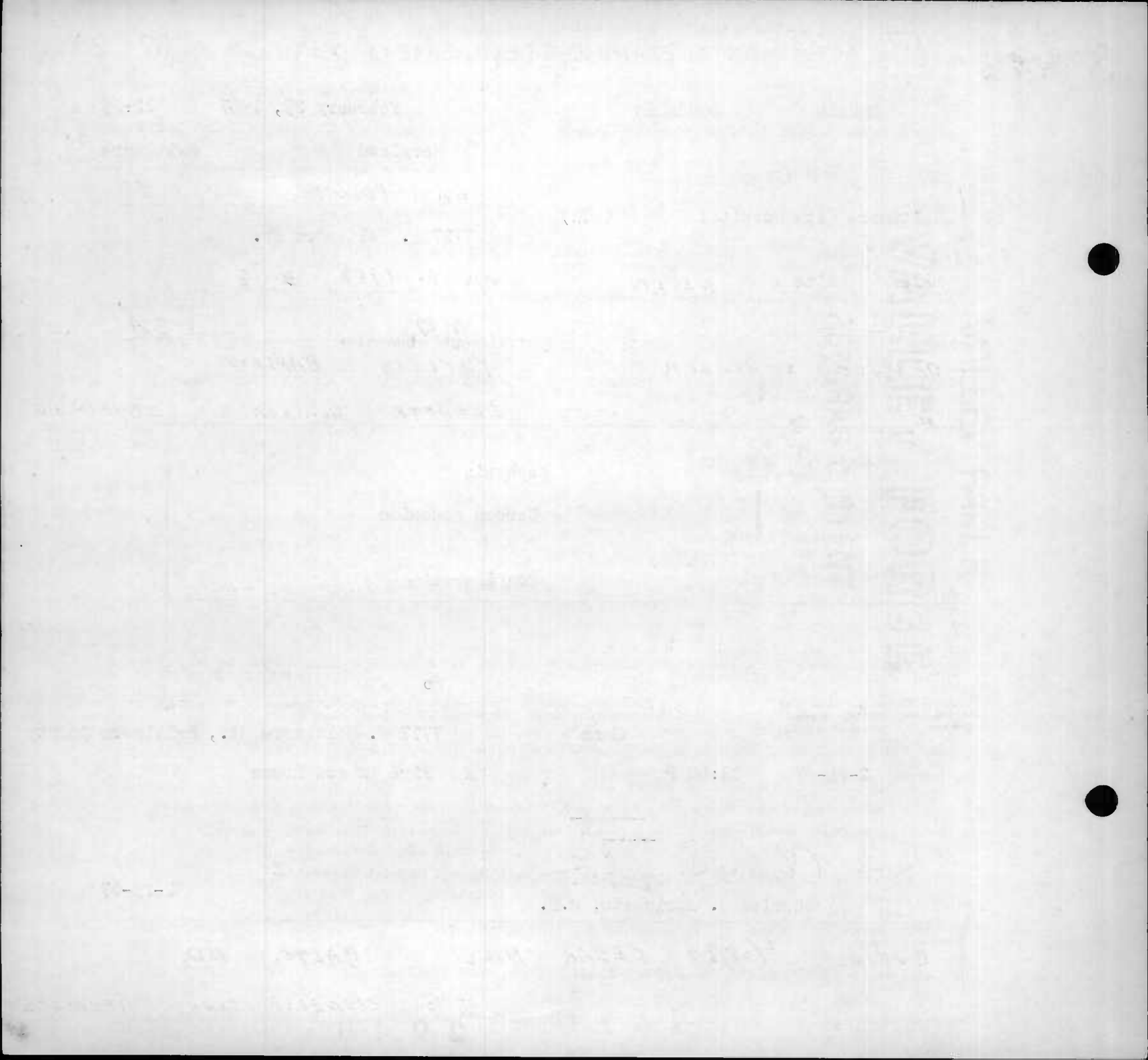
Robert E. Fairley, M.D.

24C. FUNERAL DIRECTOR

J.G. CONNELLY SONS

ADDRESS

300 MACE



1
5-636

67 2034

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2034

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PAULA SCHRADER

2. DATE AND HOUR PRONOUNCED DEAD

February 25-1967 12:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

7727 E. Baltimore St.

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

3/20/1961

9. AGE (In years
last birthday)

5

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

DONALD SCHRADER

14. MOTHER'S MAIDEN NAME

BARLOW

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ELEANOR HOMODA
PAULA S

ADDRESS

284-0246

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Asphyxia

Carbon monoxide

(B) DUE TO

Conflagration

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

7727 E. Baltimore St., Baltimore County

21D. TIME OF INJURY
(APPROX.)

2-24-67

(Month) (Day) (Year) (Hour)

11:40 P

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

Fire in row house

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-25-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

2/28/67

23C. NAME OF CEMETERY or CREMATORY

CEDAR HILL

23D. LOCATION

(City, town, or county)

BALTO. MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 1 1967

24B. NAME OF REGISTRAR

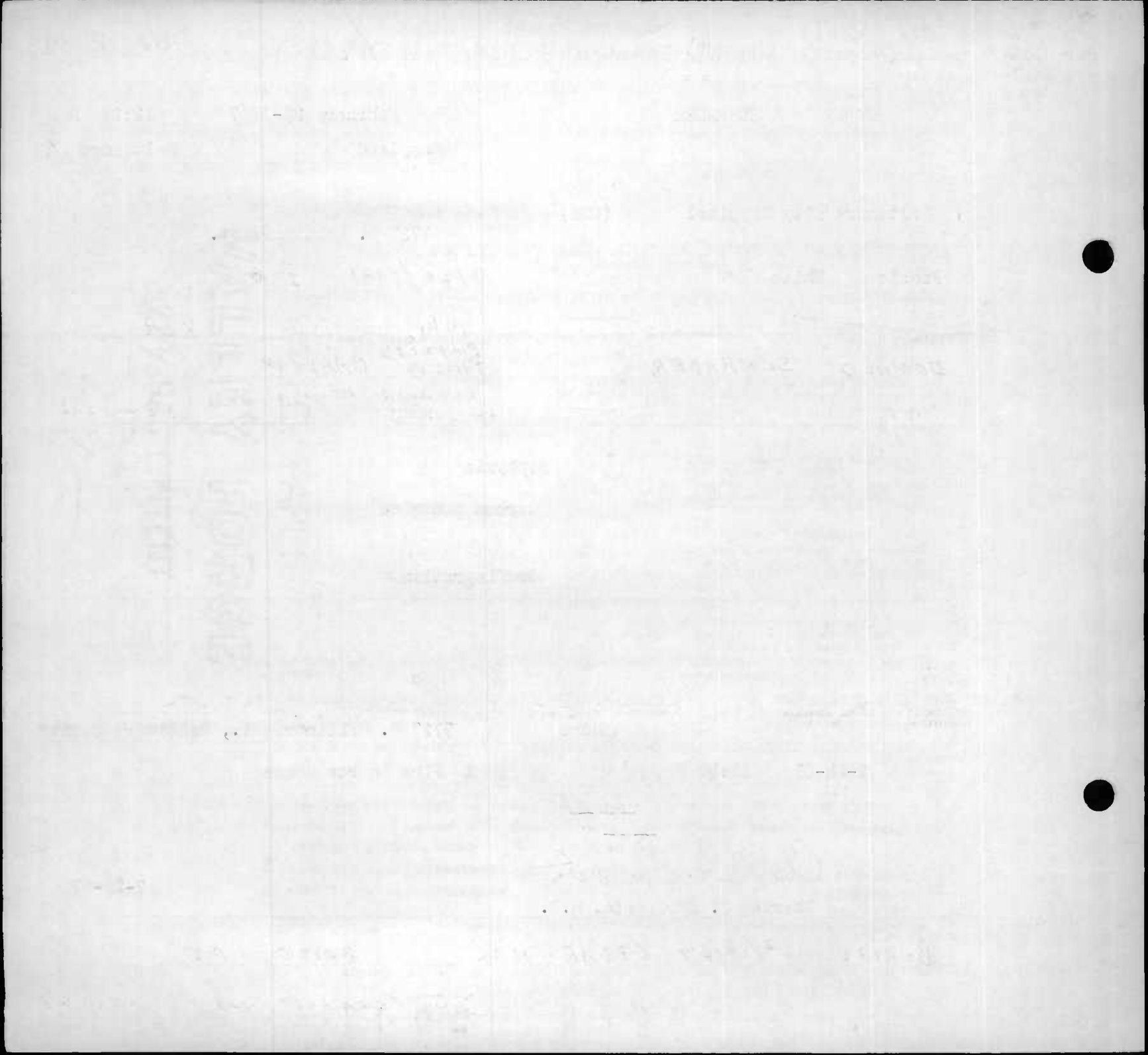
Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

J.G. CONNELLY SONS

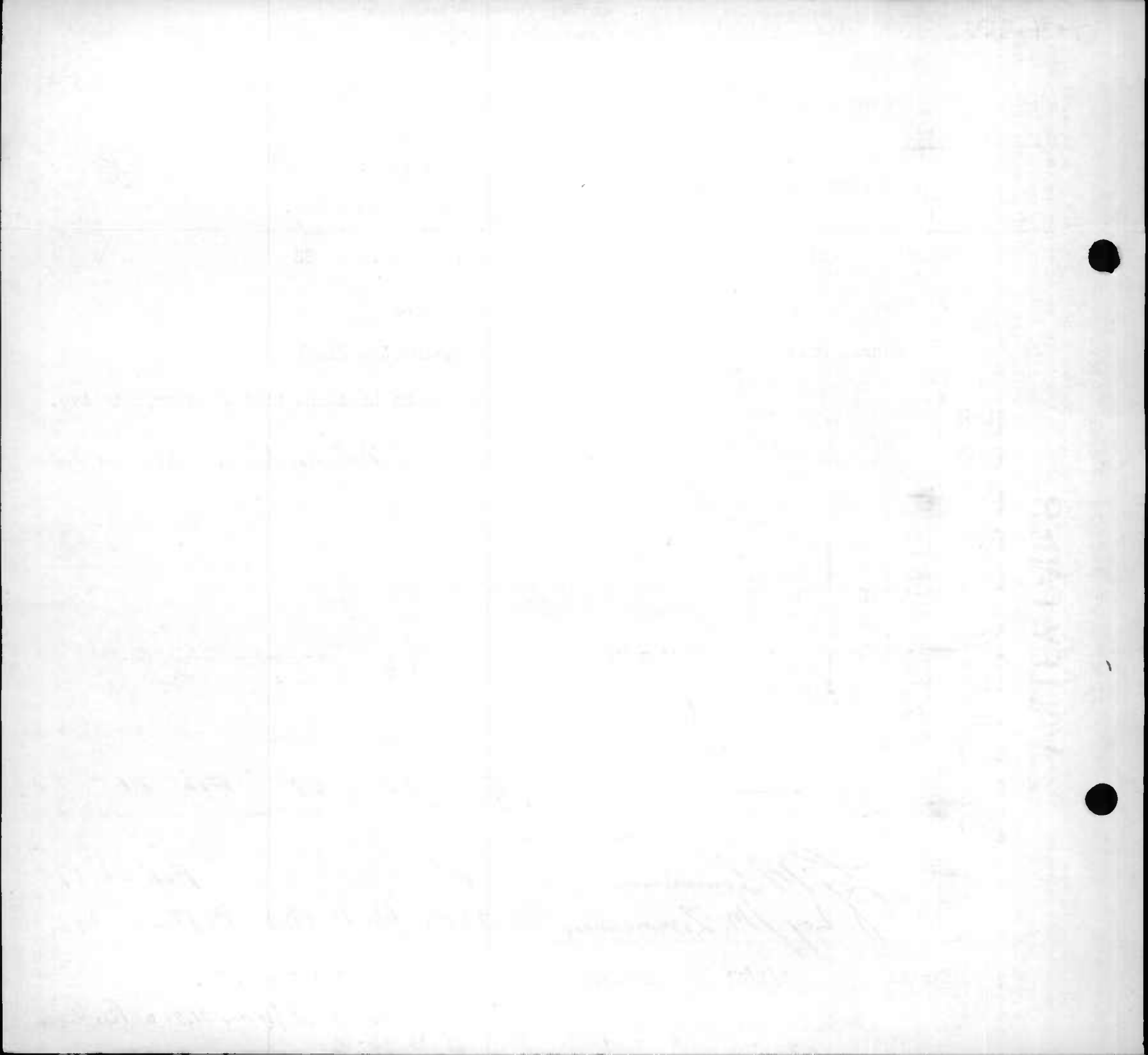
ADDRESS

300 MACE



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| B-426 | | 67 2035 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2035 | |
| BIRTH NO. | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Josephine Ballach | | | | Feb. 26, 1967 | | 11:55 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Harford Gardens Home | | | | A. STATE Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) 2905 Erdman Ave. | | | | 5. SEX Female | | | |
| | | | | 6. RACE White | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | | | 8. DATE OF BIRTH Aug. 12, 1878 | | 9. AGE (In years lost birthday) 88 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME Conrad Dietz | | | |
| 14. MOTHER'S MAIDEN NAME Katherine Flach | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Mrs. Arthus Listman, 2825 Chesterfield Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 450.01 Generalized Atherosclerosis | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH Several Years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | | |
| | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 20 19 67 to Feb 26 19 67, that (I) (we) last saw the deceased alive on Feb 24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Loy M. Zimmerman</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Feb. 26, 67 | |
| 23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman | | | | 23D. ADDRESS 3202 Harford Rd. Baltimore, Md. | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | | 24B. DATE 3/1/67 | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Farkner | | 25C. FUNERAL DIRECTOR William L. Horn | | ADDRESS 4210 Belair | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------------------|---|--|--|---|
| BIRTH NO. 67 2036 | | CERTIFICATE OF DEATH | | 67 2036 | |
| M.E. CASE NO. | | | 2-27-67 10:25 A.M. | | |
| 1. NAME OF DECEASED (Type or Print) ELENN ROBERT VEST | | | 2. DATE AND HOUR OF DEATH | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL-1 36 | | | A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Harewood Park (20) 53-00 | | |
| D. STREET ADDRESS (If rural, give location) 475 1/2 CORNELL ROAD 20 | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4/22/28 | 9. AGE (In years last birthday) 38 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR | | 10B. KIND OF BUSINESS OR INDUSTRY SHIP FITTERS | | 11. BIRTHPLACE (State or foreign country) PARSONS, W. VA. | |
| 13. FATHER'S NAME HARVEY VEST | | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No | | | 16. SOCIAL SECURITY NO. 235 34 2810 | | 17. INFORMANT Ruth Vest |
| | | | ADDRESS Same | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 3-76X I generalized peritonitis | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/17/67 19 to 2/27/67 19, that (I) (we) last saw the deceased alive on 2/27/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Honorio R. Ylizarde | | | | 23B. DATE SIGNED 2/27/67 | |
| 23C. PHYSICIAN'S NAME (Type) HONORIO R. YLIZARDE JR. | | | | 23D. ADDRESS FRANKLIN SQUARE HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/67 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 24E. (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Jarboe | | 25C. FUNERAL DIRECTOR Bruzdinski | |
| | | | | ADDRESS Funeral Home 1407 Eastern Ave. | |

Harwood Park (20)

225 34 2810 Ruth Voss Lane

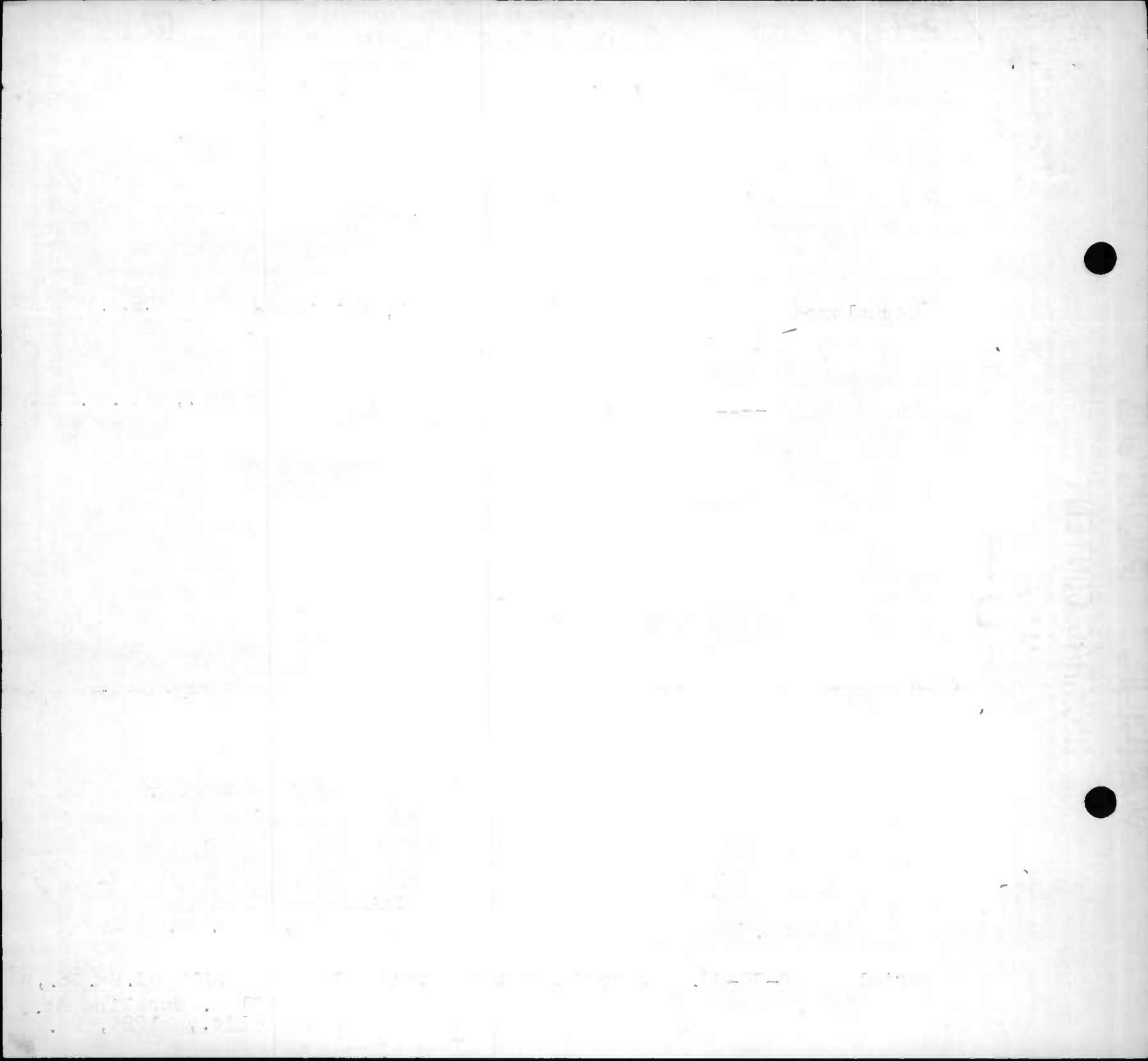
Partial 21st Jan 1960 Can 12m Century

For 1960 (over 1000) 1960

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|---|---|---|---|
| 47-03-44 IW | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2037 | |
| BIRTH NO. 67 2037 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | FRANK YOUNGBAR, JR. | | 2/24/67 12 ¹⁵ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | | A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 815 S. ROBINSON STREET - 21224 | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 4/10/14 | 9. AGE (In years last birthday) 52 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND, Baltimore | |
| 13. FATHER'S NAME FRANK S. YOUNGBAR | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 334 X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) POSS GRAM NEG TOXIS. (B) Cerebral palsy. (C) | | |
| 19. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 1/13 1967 to 2/24 1967, that (I) (we) last saw the deceased alive on 2/24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Peter F. Rosen | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/24/67 |
| 23C. PHYSICIAN'S NAME (Type) PETER F. ROSEN | | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue, Balto. Md. 21224 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-28-67 | 24C. NAME OF CEMETERY or CREMATORY Sacred Heart Cemetery | | 24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd. Ba. Co., Md |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Adams | | 25C. FUNERAL DIRECTOR 901 S. Conkling St. Balto., 21224, Md. | |



1
H-400

67 2038

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2038

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print) ELAN

W.

HALL

2. DATE AND HOUR PRONOUNCED DEAD

February 27, 1967

8:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore
1430 Light Street

23-02

D. STREET ADDRESS (If rural, give location)

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

12-9-14

9. AGE (In years last birthday)

52

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Contractor

10B. KIND OF BUSINESS OR INDUSTRY

Homes

11. BIRTHPLACE (State or foreign country)

Alabama

12. CITIZEN OF WHAT COUNTRY

USA

13. FATHER'S NAME

Don Hall

14. MOTHER'S MAIDEN NAME

Chickie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

416121793

17. INFORMANT

Bessie Hall - 722 E. Montgomery St.

ADDRESS Baltimore 30, Md

18. E 90 3.5

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Cranio-cerebral Injuries DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Lombard & Hanover Sts. on sidewalk.

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) 2 26 '67 Approx 1:40A

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Apparently Fell. 22-01

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Rudiger Breiteneker, M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

2/27/67

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

3-2-67

23C. NAME OF CEMETERY or CREMATORY

Glen Haven

23D. LOCATION

Glen Burnie, Md

24A. DATE REC'D BY HEALTH DEPT.

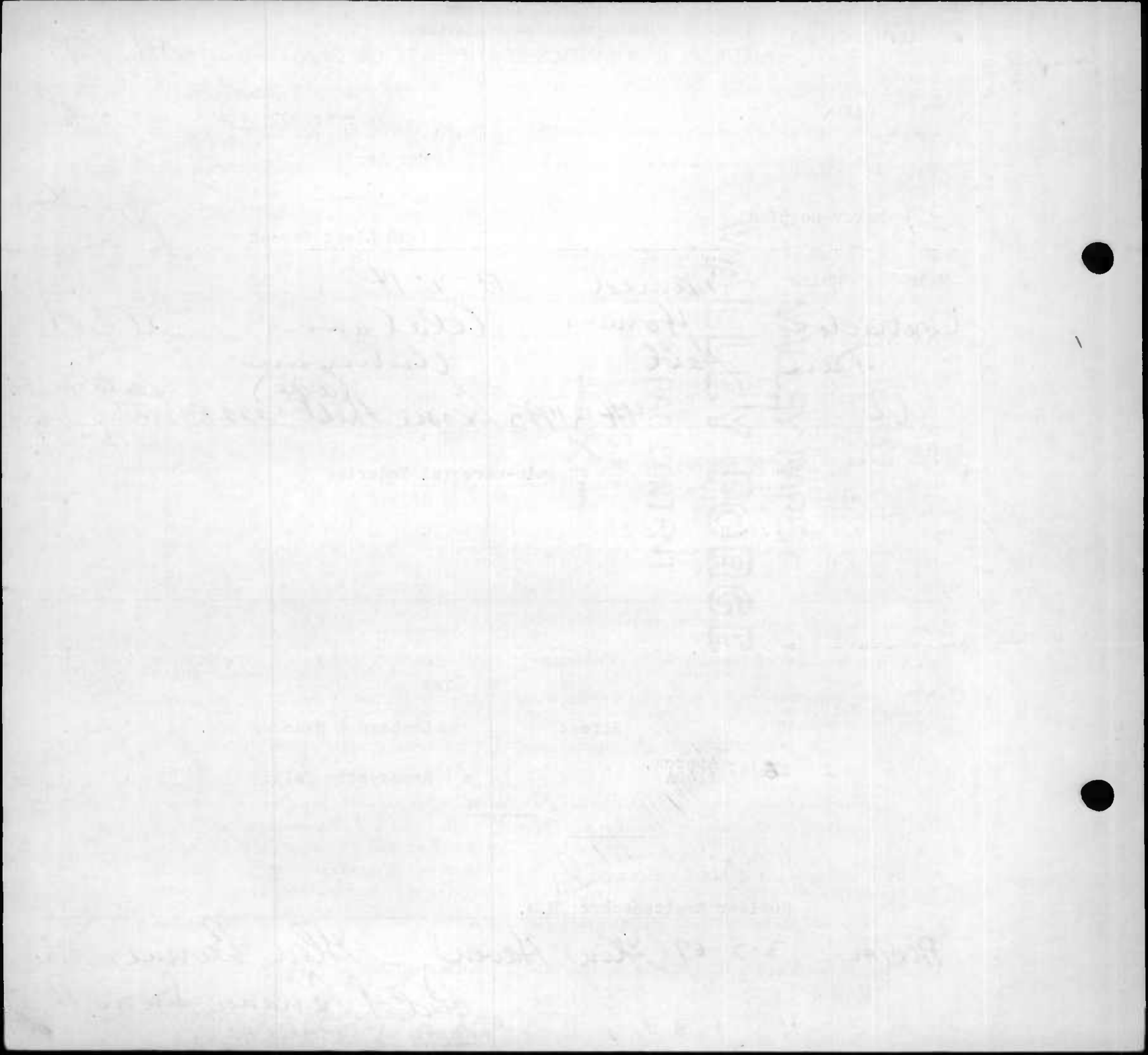
MAR 1 1967

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Robert S. Barbanco, Severna Park, Md



1
C-463

| BIRTH NO. 67 2039 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2039 | |
|---|---------|--|------------------|--|--|
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| | | Frank CLARIDGE | | February 25, 1967 10:20 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | |
| | | Maryland | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| 00 1208 Hanover Street | | Baltimore | | 23-01 | |
| D. STREET ADDRESS (If rural, give location) | | 1208 Hanover Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| Male | White | Widowed | 2/23/87 | 80 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Watchman | | Shipyard | | Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| | | - | | - | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes WW I | | | | Mrs. Nicie Simmons 1208 S. Hanover St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.0 I | | Arteriosclerotic heart disease | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | Charles S. Springate, M.D. | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3/1/67 | | Baltimore National | |
| | | | | 23D. LOCATION (City, town, or county) (State) | |
| | | | | Baltimore, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | |
| MAR 1 1967 | | Robert E. [Signature] | | JOHN F. DENNY, INC. 715 Light St. | |

WALFLEW PROFILES

AN INDEPENDENT

OF THE

WOLFLEW PROFILES

WOLFLEW PROFILES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------|--|------------------|--|--|
| BIRTH NO. | | 67 2040 | | 67 2040 | |
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Harry V. Lingelbach | | Feb 27, 1967 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 31 Baltimore City Hospital Balto., Md | | Maryland Balto. C. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | Box 538 Seneca Road Rt 14 Balto 20 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Mo. If Under 24 Hrs. Months Days Hours Min. |
| Male | White | Married | Dec 2, 1896 | 70 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Clothing Cutter | | Factory | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Theodore Lingelbach | | Phillips | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes | | 215-01-8617 | | Box 538 Seneca Park Road Rt 14 Balto, 20 MD | |
| 18. 422.1 I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) <i>Arteriosclerosis</i> | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (B) <i>C.V. Disease</i> | | | |
| ANTECEDENT CAUSES | | (C) | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/30 19 64 to 2/27 19 67, that (I) (we) last saw the deceased alive on 2/25 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Nathan Janney</i> | | | | 23B. DATE SIGNED 3/1/67 | |
| 23C. PHYSICIAN'S NAME (Type) 7101 Harford Rd. | | | | 23D. ADDRESS 7101 Harford Rd. - Balto., Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3-3-1967 | | Oak Lawn Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 1 1967 | | Robert E. Taylor, M.D. | | Leo G. Cook 7200 Harford Road | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------|---|--------------------------|--|------------------------------|
| 67 2041 | | 67 2041 | | 67 2041 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | |
| | | | | Mildred Finch | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 2. DATE AND HOUR OF DEATH | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | |
| 90 Bar-Wil-Bar Nursing Home | | Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 2541 W. Lafayette Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| Female | Negroid | widowed | 5-30-14 | 52 yrs. | U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Clarence Ward | | | Mary | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | Evelyn Wood 2609 Garrett Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 170X I | | Carcinoma of right breast with metastasis to spine | | | |
| ANTECEDENT CAUSES | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 9-24-63 | | Carcinoma of breast | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-24-1967 to 2-27-1967, that (I) (we) last saw the deceased alive on 2-27-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| C.R. Campbell | | | | 2-28-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| C.R. Campbell | | 1618 W. North Ave. Baltimore Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 3-4-67 | | Arbutus Mem. H. | |
| | | | | Arbutus, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 1 1967 | | G. E. E. Taylor | | Kelson Funeral Home 1348 Balhoun St. | |

Examination of right breast
with incision to spine

No

Examination of breast 2-24-03

2-24-03

2-24-03

2-24-03

2-24-03

was with the Baltimore

Dr. Campbell

Dr. Campbell

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2042 | |
|--|----------------------|--|---------------------------------|--|---|
| BIRTH NO. 67 2042 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ELSIE Freeman Griffin | | | |
| 2. DATE AND HOUR OF DEATH | | 2-26-67 6:10 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Md. B. COUNTY | | | |
| 37 Mercy Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 405 W. CARROLLTON Ave | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH 9-17-11 | 9. AGE (In years last birthday) 55 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balti. Md. | |
| 13. FATHER'S NAME George Freeman | | 14. MOTHER'S MAIDEN NAME Clara White | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-01326 | | 17. INFORMANT ADDRESS George Freeman 2237 Homewood Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) Laennec's Cirrhosis | | at least 7 yrs. | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| | | Renal Failure | | | |
| | | Chronic pancreatitis | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/22 19 67 to 2/26 19 67 , that (I) (we) last saw the deceased alive on 2/26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) , (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E Lee Robbins | | | | 23B. DATE SIGNED 2/27/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS Mercy Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/67 | | 24C. NAME OF CEMETERY or CREMATORY St. Lukes Cem. Balto. Md. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR E. Taylor | |
| 25C. FUNERAL DIRECTOR Williams Funeral Home | | ADDRESS 319 N. Scholten St. | | | |

~~Transcript~~

Mr. White
Mr. White
Mr. White
Mr. White
Mr. White

George Brown
Horseman
and also
Pioneer

is also George Brown 2237 Pioneer

Handwritten notes at the bottom of the page, including the word "Horse" and other illegible text.

BIRTH NO. **67 2043** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 2043**

M.E. CASE NO.

| | | | | | | | |
|--|---------------------------|--|---|---|---|--|--|
| 1. NAME OF DECEASED (Type or Print) JAMES A. SCRIBNER | | | | 2. DATE AND HOUR PRONOUNCED DEAD February 27, 1967 10:40 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2016 North East Avenue | | | |
| 5. SEX Male | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH April 9, 1903 | 9. AGE (In years last birthday) 63 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus driver | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Balto, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Luther Scribner | | | 14. MOTHER'S MAIDEN NAME Harriet Pulley | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 216-10-0168 | | | 17. INFORMANT ADDRESS Sarah Scribner 2016 Northeast Ave | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. 422.1 I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Rudiger Breiteneker, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2/27/67 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 3/3/1967 | 23C. NAME of CEMETERY or CREMATORY W. A. D. Cemetery | | 23D. LOCATION (City, town or county) (State) Balto. Md. | | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 24B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 24C. FUNERAL DIRECTOR ADDRESS Williams Funeral Home 319 N. Calhoun St. | | | |

For as before
Luther, Scribner
Harriet, Pillsbury
April 1893
Married

Arrival April 1893
Luther, Scribner
Harriet, Pillsbury

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 2044 | |
|--|-------------------------|--|--|--|--|--|--|
| BIRTH NO. 67 2044 | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) LAWRENCE | | | | 2. DATE AND HOUR OF DEATH FEB. 28, 1967 11:25 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Bon Secours Hospital | | (If not in hospital or institution, give street address or location) D.O.A. | | A. STATE MARYLAND | | B. COUNTY 20-04 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 2300 Frederick Ave. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH JAN. 14, 1883 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator | | 10B. KIND OF BUSINESS OR INDUSTRY METAL Fabricators | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph FULLER | | | | 14. MOTHER'S MAIDEN NAME Genevieve ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE | | 16. SOCIAL SECURITY NO. 215-07-0076 | | 17. INFORMANT BERTHA FULLER ADDRESS 2300 Frederick Ave | | | |
| 18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) Cerebral Thrombosis DUE TO | | 3 weeks | |
| | | | | (B) Arteriosclerosis DUE TO | | 20 yrs | |
| | | | | (C) hypertension DUE TO | | 20 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. senility | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 1964 to February 1967 , that (I) (we) last saw the deceased alive on 8th Feb 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE H.H. Baylus | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 1 March 67 | |
| 23C. PHYSICIAN'S NAME (Type) H.H. BAYLUS, M.D. | | | | 23D. ADDRESS 1600 Wilkins Ave Balt, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-4-67 | | 24C. NAME OF CEMETERY or CREMATORY LORRAINE PARK | | 24D. LOCATION (City, town, or county) (State) WOOD LAWN, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Geo. L. Schaub & Son, 2101 Frederick Ave. | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|---|--|--|
| BIRTH NO. 67 2045 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2045 | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 2-27-67 10:10 P.M. | | | |
| 1. NAME OF DECEASED (Type or Print) Esther Bolster | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTIMORE | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3-6-67 90 Little Sisters of The Poor 1200 VALLEY ST. BALTIMORE MD 21202 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 10-01 D. STREET ADDRESS (If rural, give location) 1200 VALLEY ST | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 1893 Sept. 19-1887-73 80-- | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME William Welsh | | | 14. MOTHER'S MAIDEN NAME Laura Schultz | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-03-3387 | | 17. INFORMANT Little Sisters of The Poor | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Massive myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Q.S.C.V.D. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1966 to Feb 27 1967 , that (I) (we) last saw the deceased alive on Feb 27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Stanley Ankudas | | M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2.1.67 | |
| 23C. PHYSICIAN'S NAME (Type) Stanley Ankudas | | 23D. ADDRESS M.D. 1101 Maiden Choice Lane 1200 Valley St. Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Mar 2/67 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR Robert E. Fadden | | 25C. FUNERAL DIRECTOR Philip Herwig Sons | | ADDRESS 2024 Orleans St | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2046

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Prince WHITE

2. DATE AND HOUR PRONOUNCED DEAD

February 25, 1967 11:28 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
 (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
 4-24-67

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

512 Druid Hill Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

10/6/06

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Ship Yard

11. BIRTHPLACE (State or foreign country)

Pineville, S Carolina

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

William White

14. MOTHER'S MAIDEN NAME

Cornie Gilliard

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

213-07-5218

17. INFORMANT

ADDRESS

Mr Isaac White, Rtl, Box 318, Pineville

18.

E900. Q T E322.0

CAUSE OF DEATH

S C

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Fracture of cervical spine
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Acute ethylism

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

512 Druid Hill Avenue, 2nd Floor

21D. TIME
OF INJURY
(APPROX.)

2-25-67

11:10

A.

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Fell down steps

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

February 26, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/4/67

23C. NAME OF CEMETERY or CREMATORY

Gilliard, Cemetery

23D. LOCATION

(City, town, or county)

(State)

Pineville, South Carolina

24A. DATE REC'D BY HEALTH DEPT.

MAR 1 1967

24B. NAME OF REGISTRAR

R. E. Farley, M.D.

24C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W North Ave

ADDRESS

DR. BREITENICKER, MEDICAL EXAM - REGISTERED
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH Baltimore City Health Department

Registered No. 67 2047

BIRTH NO. 67 2047

M.E. CASE NO. T-641

1. NAME OF DECEASED (Type or Print) **TREULEIB HENRY**

2. DATE AND HOUR OF DEATH **FEB 28, 1967 11:55 P.M.**

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **35 CHURCH HOME & HOSPITAL**

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE **MARYLAND**
B. COUNTY **6-02**

C. CITY OR TOWN (If outside city limits, write RURAL and give township) **117 BELNORD AVE BALTIMORE**

D. STREET ADDRESS (If rural, give location) **117 BELNORD AVE**

5. SEX **MALE** 6. RACE **WHITE** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **MARRIED**

8. DATE OF BIRTH **9-1-08** 9. AGE (In years last birthday) **58**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **CITY CLERK**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **MARYLAND**

12. CITIZEN OF WHAT COUNTRY? **U.S.A**

13. FATHER'S NAME **GEORGE TREULIEB**

14. MOTHER'S MAIDEN NAME **ELLA WILFELDEN**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) **No**

16. SOCIAL SECURITY NO. **27-509-4982**

17. INFORMANT **Mrs. Martha G. Truelieb** ADDRESS **117 N. Belnord Ave.**

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Massive Atelectasis, lung
Sub-endorthelial Ischemia
Arteriosclerosis

19. ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A), stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **2/28/67** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **POPLITEAL ARTERY (L)**

20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner examined) ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **FEB. 27 1967** to **FEB. 28 1967**, that (I) (we) lost saw the deceased alive on **11:55 P.M. 1967** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE **Manuel J. Tan** M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type) **MANUEL J. TAN** M.D.

23D. ADDRESS **CHURCH HOME & HOSPITAL**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **3/4/67** 24C. NAME OF CEMETERY OR CREMATORY **Gardens of Faith Cemetery, Baltimore, Maryland** 24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT. **MAR 1 1967** 25B. NAME OF REGISTRAR **John A. Moran, Inc.** 25C. FUNERAL DIRECTOR ADDRESS **3000 E. Baltimore St**

RECEIVED
JAN 11 1907
LIBRARY
OF THE
MUSEUM OF
COMPARATIVE ZOOLOGY
AT HARVARD UNIVERSITY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|----------------------|--|--|-------------------------------------|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>5134-73</u> <u>67 2048</u> | | | | |
| BIRTH NO. <u>67 2048</u> | | M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) <u>Williams, Leola L.</u> | | 2. DATE AND HOUR OF DEATH <u>Feb. 27, 1967</u> <u>5-10 A M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u> <u>33rd & Calvert Sts. Balto. 21218</u> | | | | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>509 Rosston ave.</u> | | | | |
| 5. SEX <u>F.</u> | 6. RACE <u>W.</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>07/17/94</u> | 9. AGE (In years last birthday) <u>72</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Eugene Rosenstein</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Marcella La Bond</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>219-10-6414</u> | | 17. INFORMANT (daughter) <u>Mrs. Lydia M. Henschel</u> | | ADDRESS <u>Balto. 3012 Summit av.</u> | | |
| 18. <u>330 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular hemorrhage (subarachnoid hemorrhage)</u> | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 15</u> 19 <u>67</u> to <u>Feb. 27</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 27</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Sang Kyun Shin</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>Feb. 27, 1967</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>SANG-KYUN SHIN,</u> <u>17826 W. Fromm</u> | | | | | 23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>3/1/1967</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Parkwood</u> | | 24D. LOCATION (City, town, or county) (State) <u>Parkville, Balto. Co., Md.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 1 1967</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Jackson</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u> | | | | |

James M. McManus
Esq. & Counsel at
Law
215 1/2
Hwy 101
Seattle, WA 98101

3

Received

References

(Subsidiary company)

Marcello J. Bore

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M. typica. Number: 8015

10/10/19

THE STATE OF W. VIRGINIA
COUNTY OF LINCOLN

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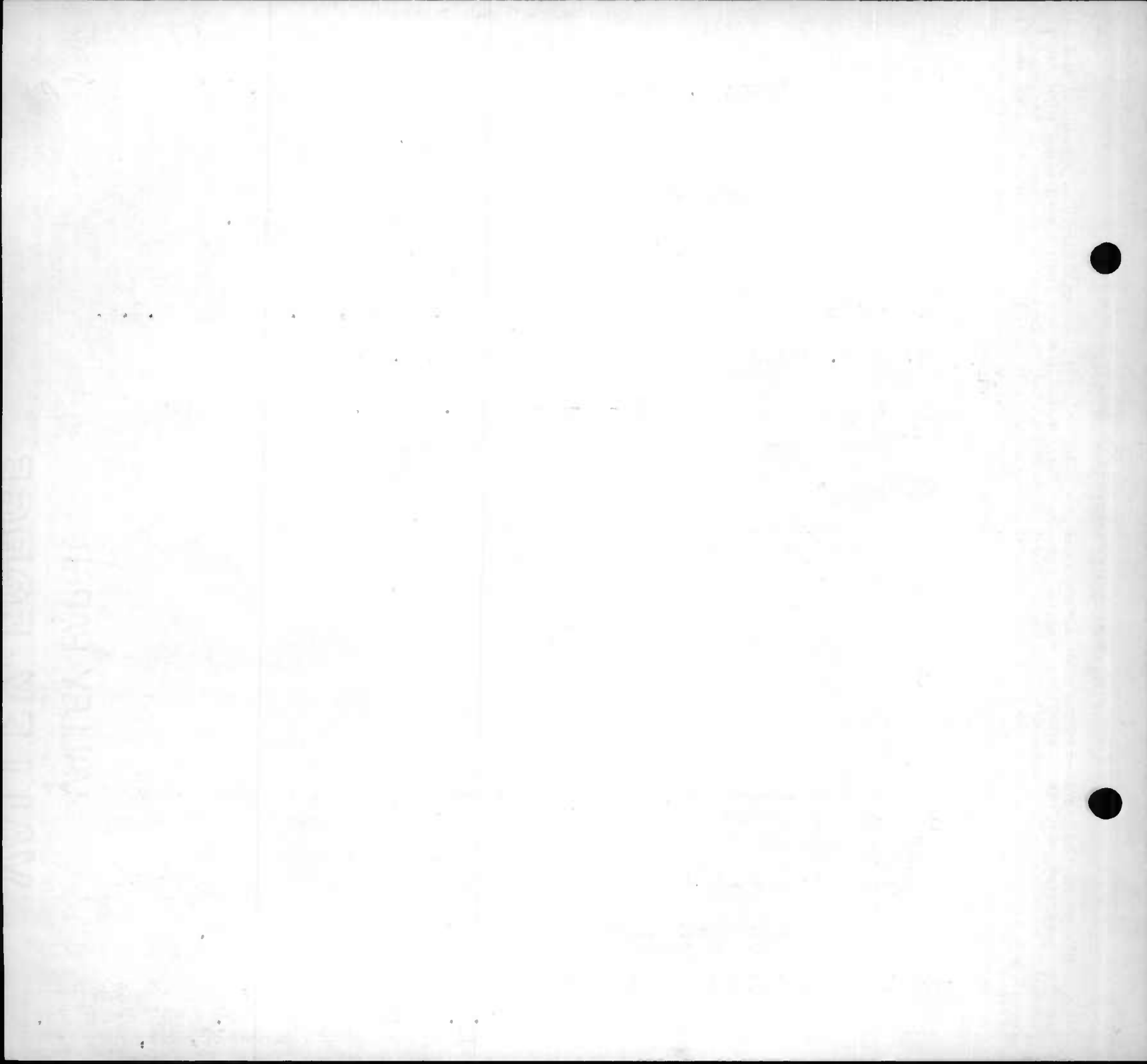
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X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2049 | |
|---|---------------------|---|--|---|--|
| BIRTH NO. 67 2049 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Leona M. Mentis | | February 27, 1967 8:52 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland B. COUNTY | | | |
| 00 6004 Loch Raven Blvd. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 6004 Loch Raven Blvd. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 4/25/1876 | 9. AGE (In years last birthday) 90 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | Own Home | | Baltimore, Md. | |
| 13. FATHER'S NAME George S. Weiss | | | 14. MOTHER'S MAIDEN NAME Eva G. Schaefer | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-46-2668 | | 17. INFORMANT Mrs. Mary M. Langhirt | |
| | | | | ADDRESS (Same) | |
| 18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH Pulmonary Edema Chronic myocarditis (A) DUE TO Hypertension Cardiovascular disease (B) DUE TO Arteriosclerosis (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1 day 4 years 20 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 10 1965 to Feb. 27 1967 , that (I) (we) last saw the deceased alive on Feb. 26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Leo Schlenger | | | | 23B. DATE SIGNED 2/27/67 | |
| 23C. PHYSICIAN'S NAME (Type) Leo Schlenger | | | | 23D. ADDRESS 6004 Loch Raven Blvd. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/1967 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | | |
| 25B. NAME OF REGISTRAR H.W. Jenkins | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2050 | |
|--|--------------|---|--|---|---|
| BIRTH NO. 67 2050 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Mary M. Kelly | | Feb. 28, 1967 2 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 Edgewood N. H. | | | A. STATE Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 716 Beaverbrook Rd. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 12-26-1893 | 9. AGE (In years last birthday) 73 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Balto., Md. | |
| 13. FATHER'S NAME Thomas B. McGee | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 220-05-2740 | | 17. INFORMANT Martin J. Kelly |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease with Cerebral Vascular Accident | | INTERVAL BETWEEN ONSET AND DEATH 6 days |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Diabetes Mellitus | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the physician) attended the deceased from <u>Mar.</u> 19 <u>60</u> to <u>Feb.</u> 19 <u>67</u> , that (I) (the physician) last saw the deceased alive on <u>Feb. 27</u> 19 <u>67</u> and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (the physician) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Wm. H. Kammer Jr.</u> | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>3/1/67</u> |
| 23C. PHYSICIAN'S NAME (Type) William H. Kammer, Jr. | | | 23D. ADDRESS 6011 York Road | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-3-1967 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR <u>R. B. E. Jenkins</u> | | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md. | |

Anterior-lateral corner
of the Discus with
Central corner of Discus

Diabetes Mellitus

Low Hb. 10.0

Feb 22

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2/1/07

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2051</u> | |
|---|-------------------------|---|---|---|---|
| BIRTH NO. <u>67 2051</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Thomas Edward Nelson</u> | | 2. DATE AND HOUR OF DEATH <u>FEBRUARY 28 1967</u> <u>9:45</u> A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>10</u> , <u>9-07</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> | | D. STREET ADDRESS (If rural, give location) <u>1611 Abbotts Lane Street</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>05-17-20</u> <u>46</u> | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>GAS ELECT. CO</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>JAMES NELSON</u> | | 14. MOTHER'S MAIDEN NAME <u>KATIE BOWIE</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>U.W.H.</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>MARY IDA NELSON (WIFE)</u> ADDRESS <u>SAME</u> | |
| 18. <u>200.01</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>UREMIA</u> | | (A) DUE TO | | <u>APPROX 3 mos.</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | <u>Chronic Pyelonephritis</u> <u>< 4 yrs.</u> | |
| | | (C) DUE TO | | <u>Obstructive Uropathy</u> <u>4 yrs</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>2-24</u> 19 <u>67</u> to <u>2-28</u> 19 <u>67</u> , that (I) <u>we</u> last saw the deceased alive on <u>2/28</u> 19 <u>67</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>James W. Carty, Jr.</u> | | | | 23B. DATE SIGNED <u>2/28/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>JAMES W. CARTY, JR.,</u> | | 23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-3-67</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Baltimore National</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR <u>Marshall W. Jones, Jr.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>1735 Harford Ave.</u> | | | |

James Watson, 1870

John Memorial Hospital

Mrs. Lige Mackie

~~Miss Lige Mackie~~ President of Association

James Watson

Mr. Lige Mackie

Watson

Association

1st Association

02-12-02

02-12-02

Katie Jones

Watson (Mrs. Lige Mackie)

James Watson

02-12-02

02-12-02

02-12-02

James Watson

James Watson

James Watson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 2052 | |
|---|-------------------------|---|--|--|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO. 67 2052 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) THOMAS A. NICHOLLS | | | | | | 2. DATE AND HOUR OF DEATH 2-25-67 11:00 A M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE DELAWARE B. COUNTY | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) NEWARK | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) 302 BEVERLY ROAD | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED | | 8. DATE OF BIRTH 7-20-59 | | 9. AGE (In years last birthday) 7 YRS | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | | | 10B. KIND OF BUSINESS OR INDUSTRY = | | 11. BIRTHPLACE (State or foreign country) Harrisberg, Penna. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ROBERT NICHOLLS | | | | | | 14. MOTHER'S MAIDEN NAME RUTH ALLEN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Robert Nicholls | | | | ADDRESS Same | |
| 18. 209.13 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) INTRACRANIAL HEMORRHAGE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arterio myelomonocytic leukemia | | | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 4 days | | | |
| | | | | | | (A) DUE TO | | | | | |
| | | | | | | (B) DUE TO | | 6 mos | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Bleeding - 61, 60 pulmonary | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 13 1967 to Feb 25 1967 , that (I) (we) last saw the deceased alive on Feb 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>H. Swick</i> | | | | | | M.D. <input checked="" type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED FEB 25 1967 | | | |
| 23C. PHYSICIAN'S NAME (Type) H. SWICK | | | | | | 23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 2-27-67 | | 24C. NAME of CEMETERY or CREMATORY Silverbrook Crematory | | 24D. LOCATION (City, town, or county) (State) Wilmington, Delaware. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>William J. Narwick</i> | | ADDRESS Newark, Del. | | | | | |

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67 2053

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2053

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIE MAE PORTER

ALIAS
(WILLIE M. FRANKLIN)

2. DATE AND HOUR PRONOUNCED DEAD

February 25, 1967 12:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1717 Orleans St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)

1717 Orleans St.

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

OCT 20, 1916

9. AGE (In years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

BEAUTICIAN

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

EDDIE THOMAS

14. MOTHER'S MAIDEN NAME

VIOLA ALLEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

ORA LEE HINNANT

ADDRESS

S/A

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Carcinoma of breast

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2-25-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

3-2-1967

23C. NAME OF CEMETERY or CREMATORY

ARBUTUS MEM. PK

23D. LOCATION

(City, town, or county)

(State)

ARBUTUS, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

MAR 1 1967

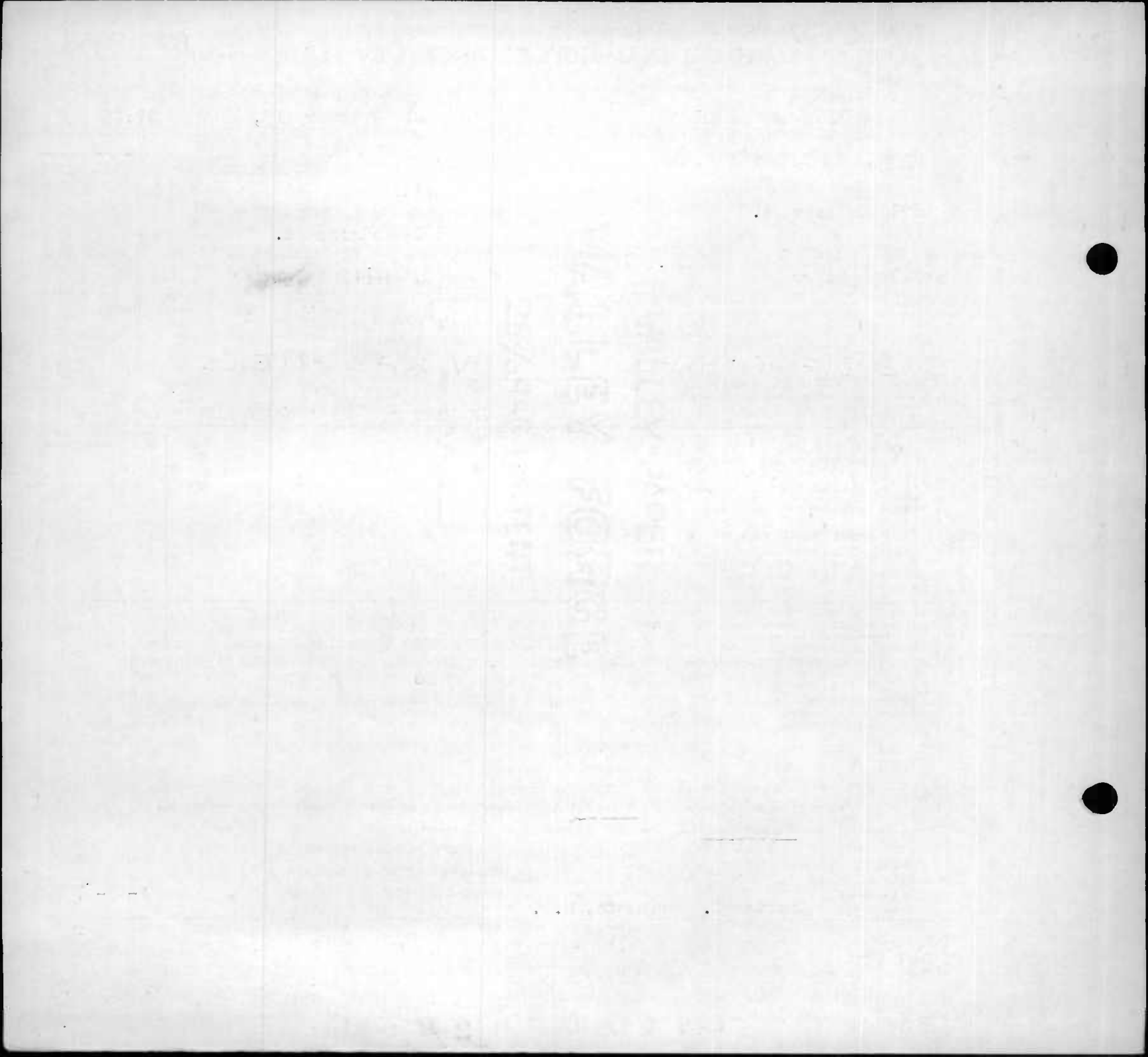
24B. NAME OF REGISTRAR

Robert E. Sankoff

24C. FUNERAL DIRECTOR

I. L. BROWN & SON 123 W. MONTGOMERY ST.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2054 | |
|---|---|---|---|--|---|
| BIRTH NO. 67 2054 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Jones, Oscar Garfield | | 2. DATE AND HOUR OF DEATH 02-28-67 4:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | 13.06 | |
| | | D. STREET ADDRESS (If rural, give location) 814 Powers Street | | | |
| 5. SEX M | 6. RACE W | 7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 05-15-82 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanist | | 10B. KIND OF BUSINESS OR INDUSTRY Manufacturing | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME Horace Jones | | 14. MOTHER'S MAIDEN NAME Anna Fedekline | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215 101136 | | 17. INFORMANT ADDRESS Edna B Jones 814 Powers St 21211 | |
| 18. 584X I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Massive G.I. Bleeding, Postoperative | | 6 hours | |
| ANTECEDENT CAUSES | | (B) Acute Cholecystitis & Cholelithiasis | | 3 days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) arteriosclerosis | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 26 Feb. 67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fair | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-25 1967 to 2-28 1967, that (I) (we) last saw the deceased alive on 2-27-9 PM 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Garfield M. Firor | | | | 23B. DATE SIGNED 2-29-67 | |
| 23C. PHYSICIAN'S NAME (Type) WARFIELD M. FIROR, WARFIELD M. FIROR | | | | 23D. ADDRESS 1 EAST 31ST STREET, 21218 1-E-31 ST BALTO 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-3-67 | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cem. | |
| 24D. LOCATION (City, town, or county) (State) P. Keesville Balto Co Md | | 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Fairbank | |
| 25C. FUNERAL DIRECTOR Burgess Funeral Home | | 25D. ADDRESS 3631 Falls Rd | | | |

4-30-4

02-28-07

Jones, Oscar

MA

Baltimore

814 Powers Street

02-12-82

N.2

MA

Anna F. ...

Horace Jones

Massive

Acute Cholecystitis

Cholelithiasis

Fair

off ...

3-22

01

3-22

3-22-82

3-22-82

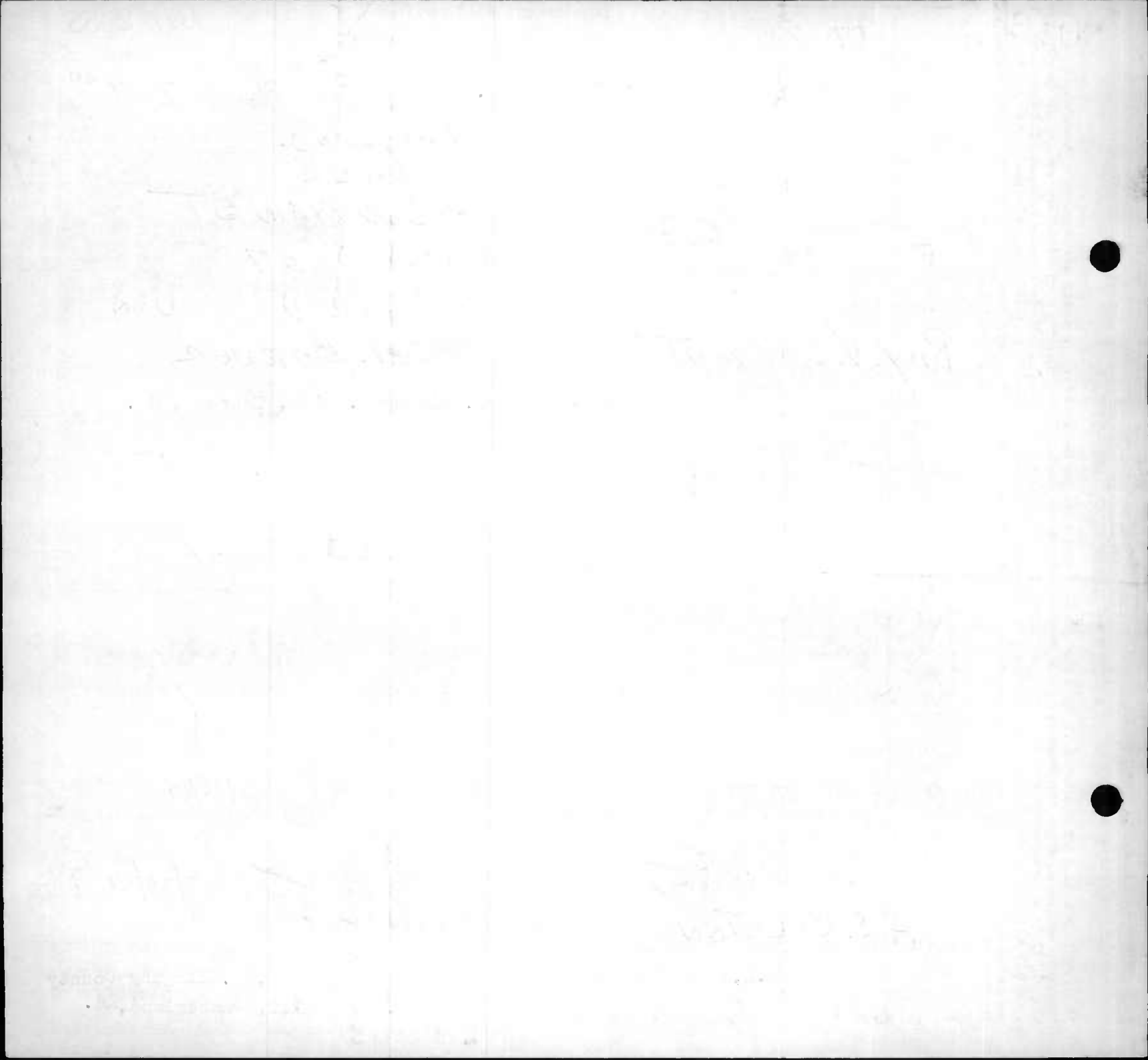
1-3-31

WATFIELD M. FIRM

FUNERAL DIRECTOR: IMPORTANT

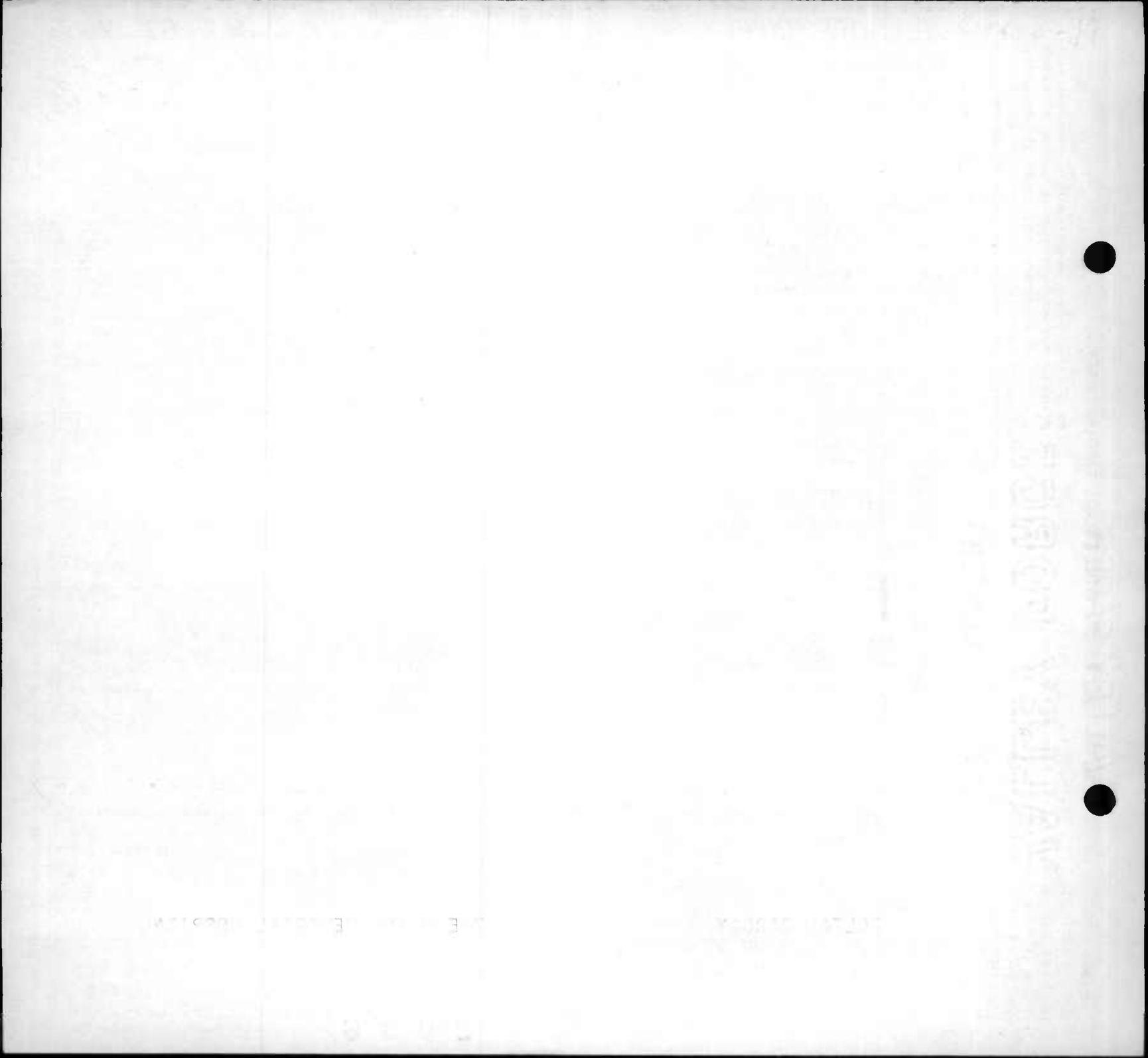
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2055 | |
|---|---------------------|---|--|---|---|
| BIRTH NO. 67 2055 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) BARBARA HITE | | 2. DATE AND HOUR OF DEATH Feb 26 1967 9⁰⁰ M | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIV. HOSP | | A. STATE MARYLAND B. COUNTY Washington Co. | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) HANCOCK 71-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) 283 W. MAIN ST | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 4-21-38 | 9. AGE (In years lost birthday) 28 27 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME RAY V. LARGENT | | 14. MOTHER'S M maiden NAME HAZEL BURGER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war & dates of service) no | | 16. SOCIAL SECURITY NO. 214-36-6763 | | 17. INFORMANT ADDRESS Mr. Wilbur E. Hite, Hancock, Md. | |
| 18. 441X I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) grand mal seizure DUE TO menia | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) malignant hypertension DUE TO chronic glomerulonephritis | | | |
| | | (C) severe heart failure 2° above | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/19/67 19 to 2/26/67 19, that (I) (we) last saw the deceased alive on 2/26/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A. C. COLSTON | | | | 23B. DATE SIGNED 2/26/67 9³⁰ PM | |
| 23C. PHYSICIAN'S NAME (Type) A. C. COLSTON | | | | 23D. ADDRESS UNIV HOSP | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Mar. 2, 1967 | | 24C. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park | |
| | | | | 24D. LOCATION (City, town, or county) (State) Cumberland, Md. Allegany County | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md. | |



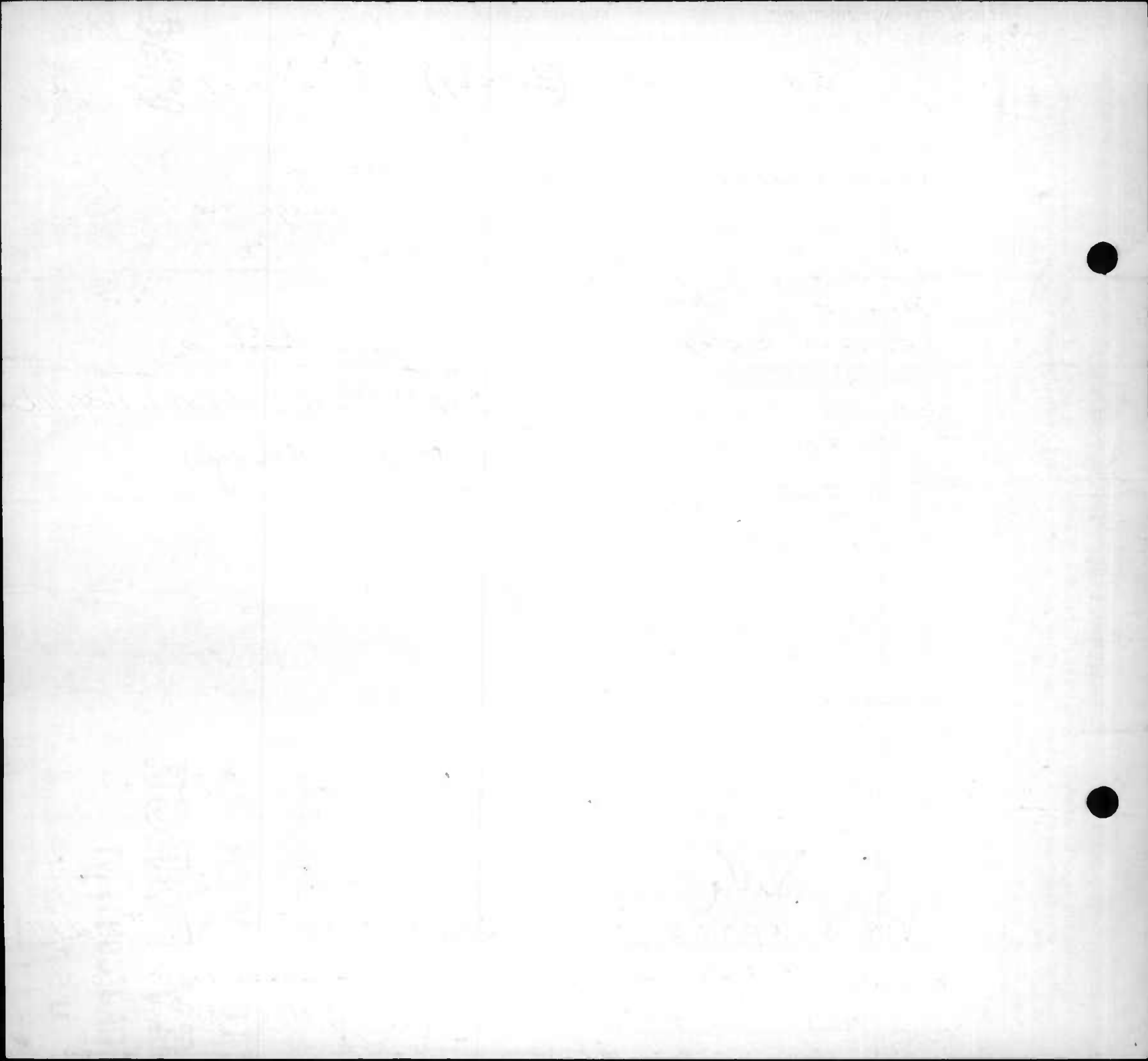
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|---------------------|--|-------------------------------------|---|---|---|------------------------|
| BIRTH NO. 67 2056 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 2056 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) SAMUEL NEUMAN | | | |
| 2. DATE AND HOUR OF DEATH 2-27-67 2:05 P.M. | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp. | | (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| D. STREET ADDRESS (If rural, give location) 3206 Chestnut Ave. | | E. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | F. STATE (If outside city limits, write RURAL and give township) MARYLAND | | G. COUNTY (If outside city limits, write RURAL and give township) BALTIMORE | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 12-13-32 | 9. AGE (In years last birthday) 34 | 10. Under 1 Yr. Months: Days: Hours: Min. | | 11. Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coach | | 10B. KIND OF BUSINESS OR INDUSTRY B.O. | | 11. BIRTHPLACE (State, or foreign country) Ind. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME NEUMAN | | | | 14. MOTHER'S MAIDEN NAME ELVIRA HATFIELD | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family | | ADDRESS Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.1 I MYOCARDIAL INFARCTION | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 02-22 1967 to 02-27 1967 , that (I) (we) last saw the deceased alive on 02-27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Zoltan Zarday | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2-27-67 | |
| 23C. PHYSICIAN'S NAME (Type) ZOLTAN ZARDAY | | | | 23D. ADDRESS M.D. THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) B | | 24B. DATE 3/3/67 | | 24C. NAME OF CEMETERY or CREMATORY Green Haven | | 24D. LOCATION (City, town, or county) (State) Balt | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR 210 S. E. 13th St. | | ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2057 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 2057 | |
|---|------------------|--|--------------------------------|--|--|---|-----------------------|
| 1. NAME OF DECEASED (Type or Print) EISELY, HORACE. (Eisely) | | | | 2. DATE AND HOUR OF DEATH 2-25-67 2²⁵ a. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GENERAL Hosp. 49 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore city. 53-00 D. STREET ADDRESS (If rural, give location) 1223 FUSCLAGE AV. | | | |
| 5. SEX M. | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 5-4-09 | 9. AGE (In years last birthday) 58 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST | | 10B. KIND OF BUSINESS OR INDUSTRY MACHINE CRAFT | | 11. BIRTHPLACE (State or foreign country) Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME EDWARD EISELY Pa. | | | | 14. MOTHER'S MAIDEN NAME DRY ELIZABETH LINK Pa. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS North Charles General Hospital | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Ca of the esophagus | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-19 1967 to 2-25-67 19 , that (I) (we) last saw the deceased alive on 2-05 A.M. 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE C. J. Hopkins | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2-25-67 | |
| 23C. PHYSICIAN'S NAME (Type) DR. J. HOPKINS | | | | 23D. ADDRESS M.D. 205 W. LANVALE ST. #21217 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/28/67 | | 24C. NAME OF CEMETERY or CREMATORY GARDENS OF FAITH | | 24D. LOCATION (City, town, or county) (State) 300 MARY BALTO. MD | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Grubbs & H. | | ADDRESS 300 MARY | |



1
W-450

67 2058

BALTIMORE CITY HEALTH DEPARTMENT

67 2058

BIRTH NO. *Balto, Md*

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JEFFERY R. WHALEN
Jeffrey Whelan

2. DATE AND HOUR PRONOUNCED DEAD

February 25, 1967 10:45 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

CERTIFICATE AMENDED
FULL NAME OF HOSPITAL OR INSTITUTION
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION
3-8-67

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland *Balto. Co.*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore *53-00*

D. STREET ADDRESS (If rural, give location)

954 Lance Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never married

8. DATE OF BIRTH

12/21/66

9. AGE (In years
last birthday)

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

2

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF
WHAT COUNTRY?

US &

13. FATHER'S NAME

RICHARD F.

14. MOTHER'S MAIDEN NAME

BEVERLY MADDOX WHELEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RICHARD F. WHELEN WHALEN

18. *525X1*

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) *Interstitial pneumonitis (SDII)*
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.
etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

1 Month 1 Day 1 Year 1 Hour

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

February 26, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2/27/67

23C. NAME of CEMETERY or CREMATORY

Garden of Faith

23D. LOCATION

(City, town, or county)

Balto. Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 1 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

J. J. Connelly, Jr.

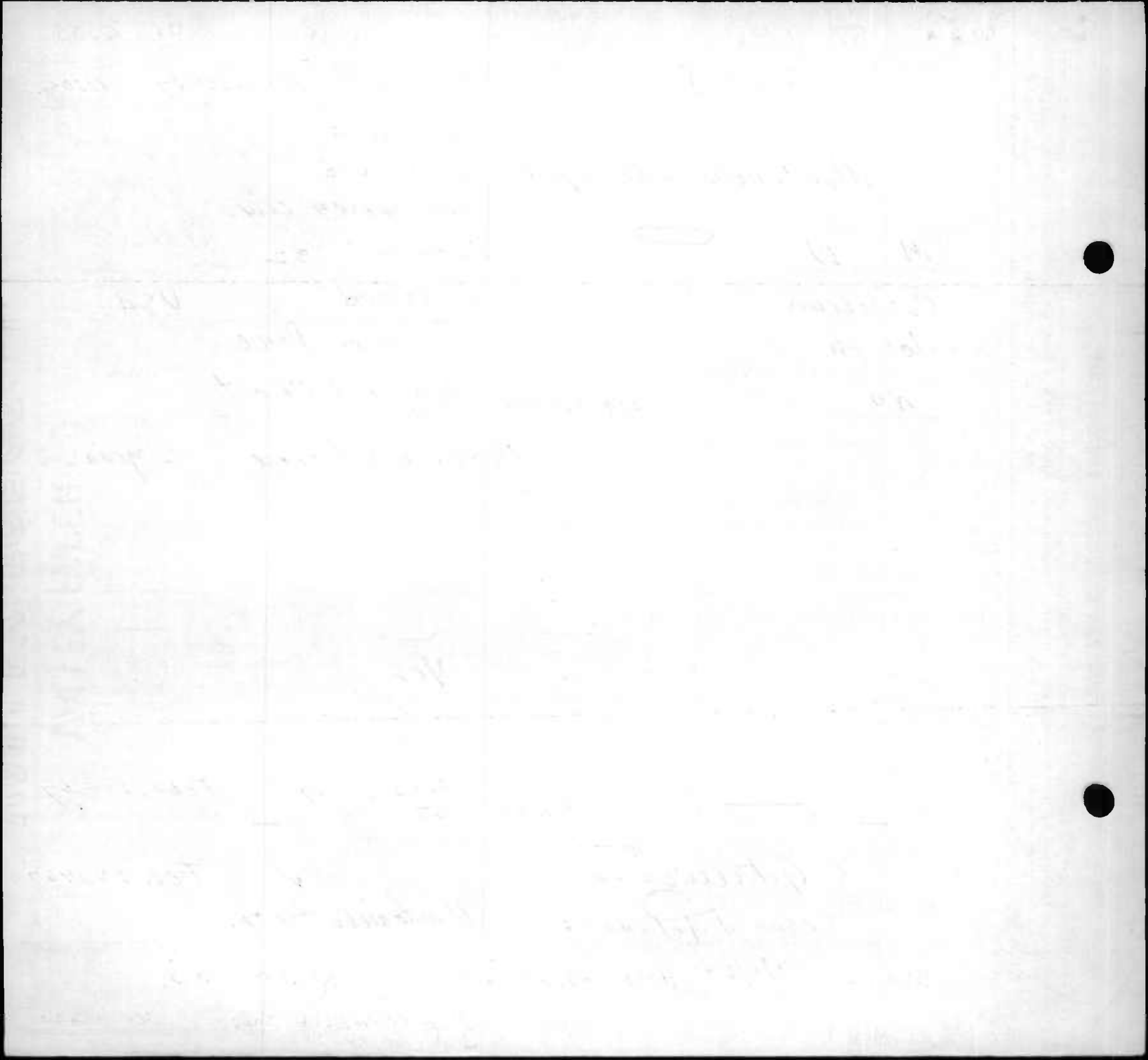
ADDRESS

300 Mace

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2059 | |
|--|---------------------|--|--|--|--|
| BIRTH NO. 67 2059 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) David P. Gomeringer | | 2. DATE AND HOUR OF DEATH Febr-25/67 11:05 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 91 Montebello State Hosp. | | A. STATE Maryland | | B. COUNTY Balto Co | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | 53-00 | |
| | | D. STREET ADDRESS (If rural, give location) 706 Dorsey Ave. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 9-19-34 | 9. AGE (In years last birthday) 32 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Joseph | | 14. MOTHER'S MAIDEN NAME Wilhelmina Price | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-32-4713 | | 17. INFORMANT Hospital Chart | |
| 18. 201X I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hodgkin's Disease | | INTERVAL BETWEEN ONSET AND DEATH 2 years. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Febr. 2, 1967 to Febr. 25, 1967 , that (I) (we) last saw the deceased alive on Feb. 25, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C. J. Keenan | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Febr. 25, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) Cesar J. Pellerano | | 23D. ADDRESS Montebello Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/1/67 | | 24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER | |
| 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR J. E. Connelly | | 25C. FUNERAL DIRECTOR J. E. CONNELLY SONS | |
| | | | | ADDRESS 300 MACE | |



BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2060

| | | | |
|--|-------------------------|--|-----------------------------------|
| BIRTH NO. 67 2060 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) <i>Dewald, Lynch</i> | | 2. DATE AND HOUR OF DEATH <i>2-25-67 6:50 P.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>City Hospital</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | |
| ADDRESS <i>4940 Eastern Avenue Baltimore, Maryland #21224</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>ESSEX 53-00</i> | |
| D. STREET ADDRESS (If rural, give location) <i>412 Dorsey Avenue #21221</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>4-5-01</i> |
| 9. AGE (In years last birthday) <i>65 Y</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MACHINIST</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>John</i> | | 14. MOTHER'S MAIDEN NAME <i>Anna Keel</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i> | | 16. SOCIAL SECURITY NO. <i>214-03-4379</i> | |
| 17. INFORMANT <i>BCH 4940 Eastern Avenue</i> | | ADDRESS <i>Baltimore, Maryland #21224</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <i>Brain tumor</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>Several months</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <i>2-23-67</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Craniotomy</i> | |
| 20A. AUTOPSY? (Yes or No) <i>Yes</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2-23-</i> 19 <i>67</i> to <i>2-25-</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>2-25-</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Carlos Uriarte</i> | | 23B. DATE SIGNED <i>FEB. 25, 1967</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Carlos Uriarte</i> | | 23D. ADDRESS <i>4940 Eastern Avenue City Hospital Baltimore, Maryland #21224</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>3/1/67</i> | |
| 24C. NAME OF CEMETERY OR CREMATORY <i>OAK LAWN</i> | | 24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>J. G. CONNELLY SONS</i> | |
| 25C. FUNERAL DIRECTOR <i>J. G. CONNELLY SONS</i> | | ADDRESS <i>300 MACE</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Gift Hospital

W. W. W.

Gift Hospital

Gift Hospital

Gift Hospital
Gift Hospital

Gift Hospital

FUNERAL DIRECTOR: IMPORTANT

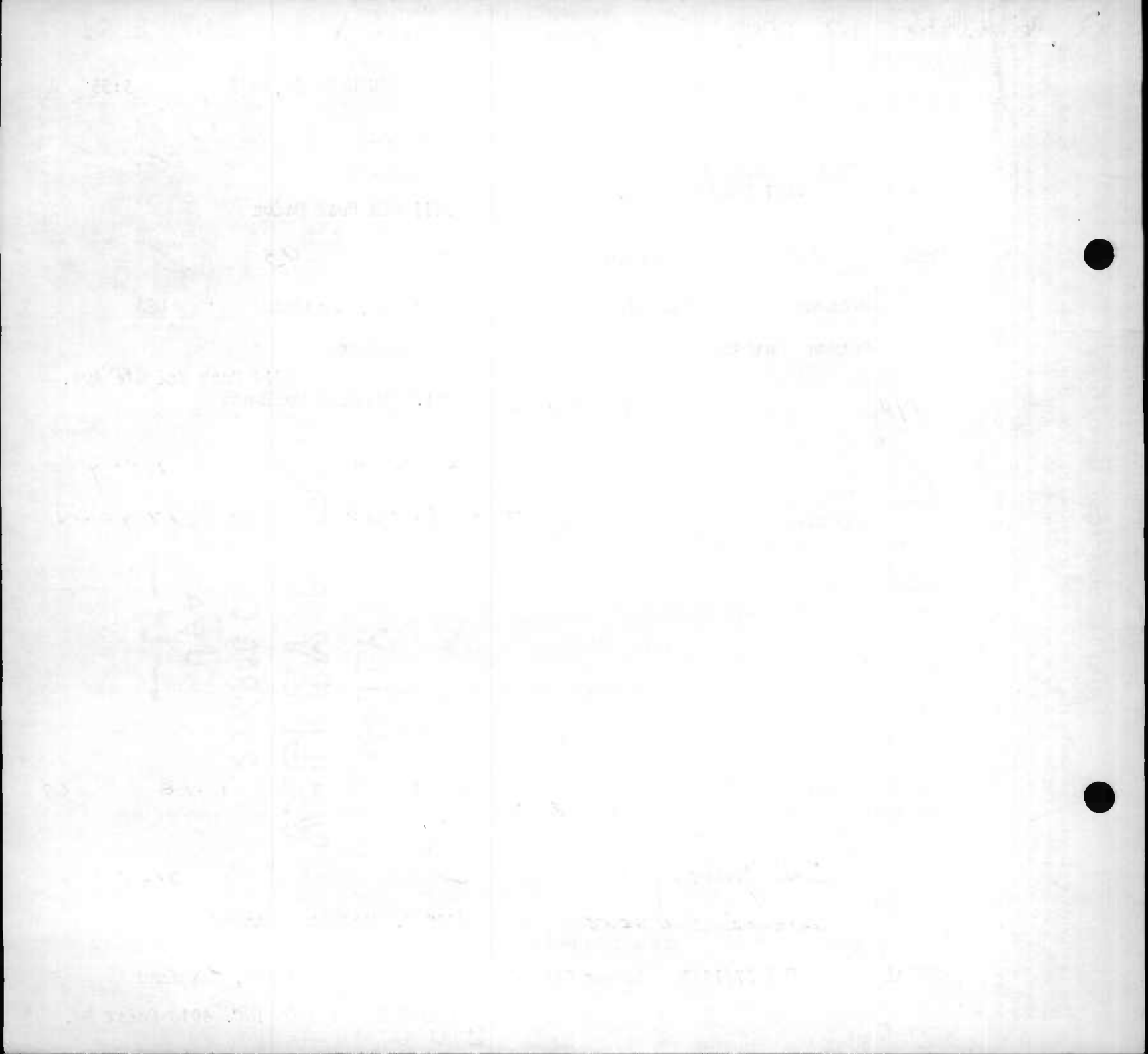
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2061</u> | |
|--|----------------------------|--|---|---|--|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. <u>67 2061</u> CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Sophia Pavsner</u> | | | 2. DATE AND HOUR OF DEATH <u>2-26-67</u> <u>550</u> A.M. | | |
| 3. PLACE OF DEATH <u>IN BALTIMORE, MARYLAND</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital of Baltimore</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Randallstown</u> <u>53-00</u> D. STREET ADDRESS (If rural, give location) <u>8434 Allenswood Rd.</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED <u>WIDOWED</u> DIVORCED (specify) | 8. DATE OF BIRTH <u>5-21-02</u> | 9. AGE (In years lost birthday) <u>64</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Hyman Hornstein</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mollie ?</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>217-03-3970</u> | | 17. INFORMANT <u>Mrs. Marilyn Gelblym, 8434 Allenswood Road</u> ADDRESS | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) <u>Rheumatic Heart Disease</u> <u>30 yrs.</u> DUE TO (B) <u>Rheumatic Fever</u> <u>?</u> DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>2-23</u> 19 <u>67</u> to <u>2-26</u> 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2-26</u> 19 <u>67</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Allen S. Rudolph</u> M.O. | | | | 23B. DATE SIGNED <u>2-26-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Allen S. Rudolph</u> M.D. | | | | 23D. ADDRESS <u>Sinai Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>2/27/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Beth Hamedrosh Hagodol</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 1 1967</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. ...</u> | | 25C. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> ADDRESS | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

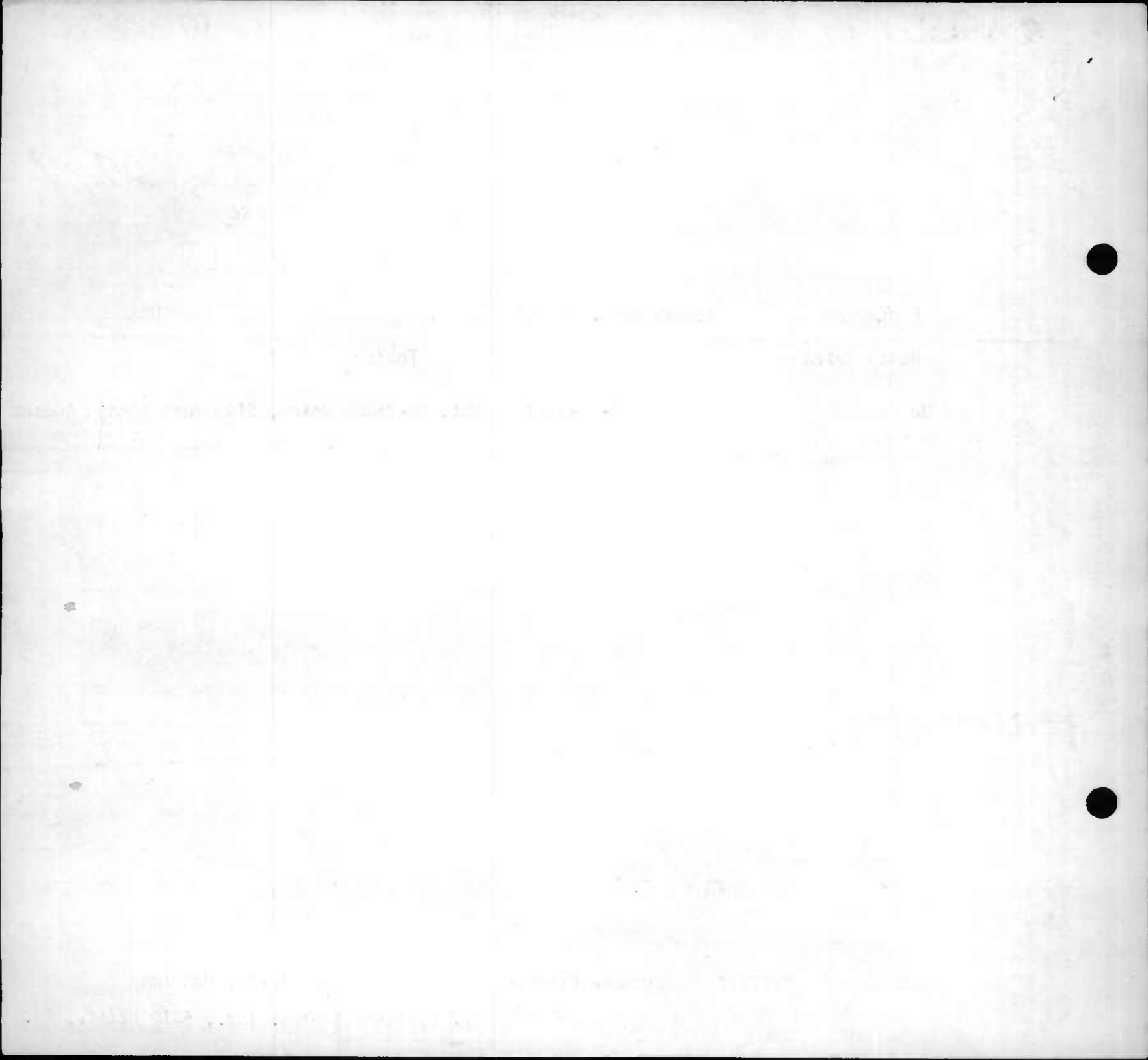
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2062 | |
|--|-------------------------|--|-------------------------------|--|--|
| BIRTH NO. 67 2062 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) EMANUEL BUXBAUM | | 2. DATE AND HOUR OF DEATH FEBRUARY 26, 1967 5:35 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balts Co. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 Jewish Convelesant Home 4601 Pall Mall Rd. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) 3411 Old Post Drive | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH 93 | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY Clothing | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Herman Buxbaum | | | |
| 14. MOTHER'S MAIDEN NAME Henrietta ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 212-18-4223 | | 17. INFORMANT 6414 Park Heights Ave. Mrs. Bryndell Wohlmuth | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) C. V. A. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. H. A. S. H. D. | | INTERVAL BETWEEN ONSET AND DEATH 1 day 17 years | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/6/23 19 31 to 2/26 19 67 , that (I) (we) last saw the deceased alive on 2/26/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Israel Zinberg | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2/26/67 | |
| 23C. PHYSICIAN'S NAME (Type) ISRAEL ZINBERG | | 23D. ADDRESS M.D. 4000 W. Northern Parkway | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE FEB 27/1967 | | 24C. NAME of CEMETERY or CREMATORY Hebrew Friendship | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS INC. 6010 Reist Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

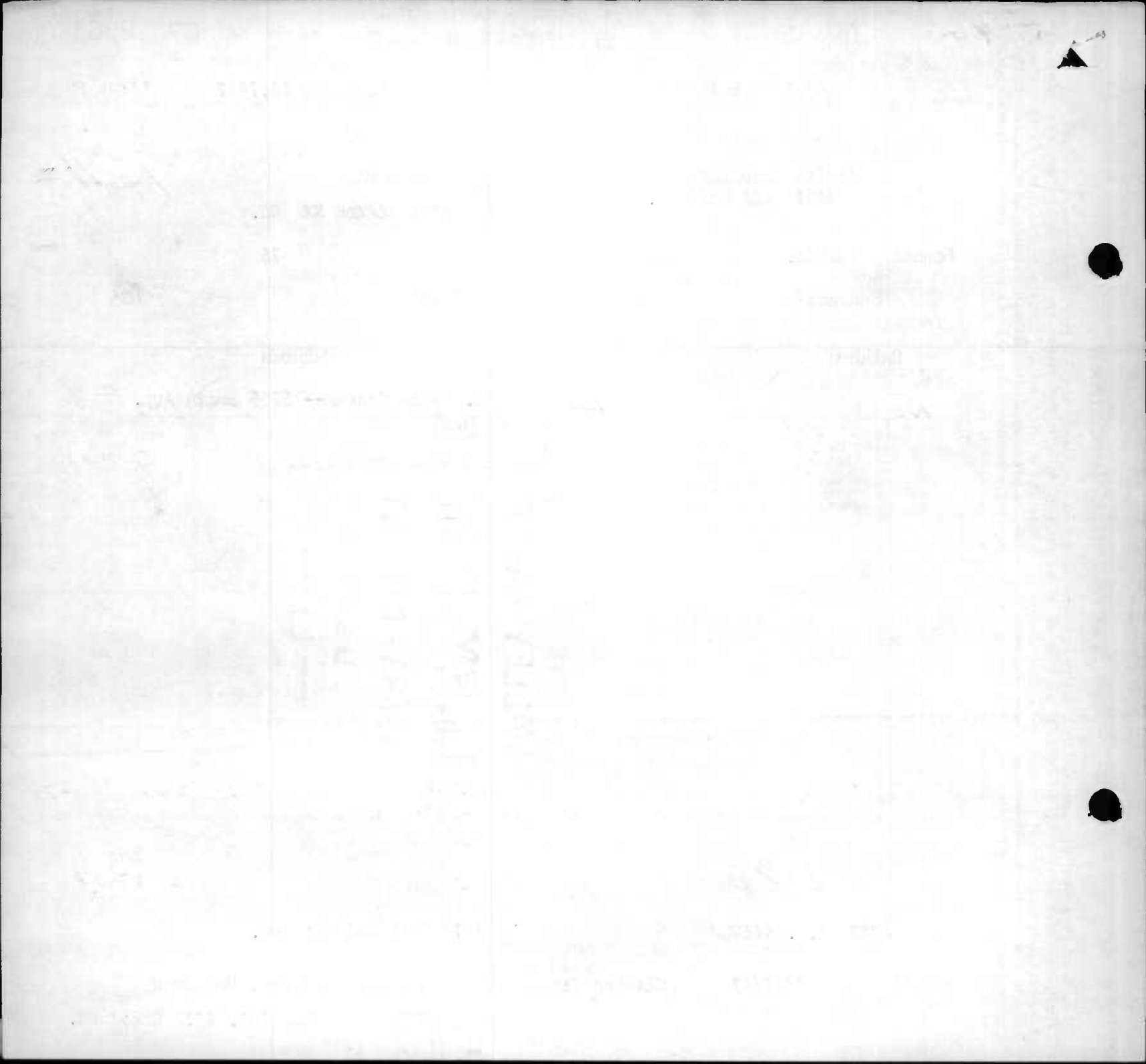
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2063 | |
|---|---------------------|---|---|--|---|
| BIRTH NO. 67 2063 | | | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) Rosen, Samuel | | | 2. DATE AND HOUR OF DEATH Feb. 26th 1967 11.50 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND Sinai Hospital of Baltimore FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Ba Md. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5103 Queensberry Ave | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M. | 8. DATE OF BIRTH 7/10/92 | 9. AGE (In years last birthday) 74 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee | | 10B. KIND OF BUSINESS OR INDUSTRY Jewish Comm. Center | | 11. BIRTHPLACE (State or foreign country) Russia | |
| 13. FATHER'S NAME Henry Rosen | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 14. MOTHER'S MAIDEN NAME Tobie ? | | 16. SOCIAL SECURITY NO. 045-05-6741 A |
| 17. INFORMANT Mrs. Gertrude Rosen, 5103 Queensberry Avenue | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.11 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Acute Pulmonary Edema (B) Acute Myocardial Infarction (C) ASCVD | | |
| INTERVAL BETWEEN ONSET AND DEATH 2 hours 8 hours Unknown | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 17th 1967 to Feb. 26th 1967 , that (I) (we) last saw the deceased alive on Feb. 26th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | | | 23B. DATE SIGNED 2/26/67 | |
| 23C. PHYSICIAN'S NAME (Type) William Cieplinski | | | | 23D. ADDRESS Sinai Hospital of Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/27/67 | | 24C. NAME OF CEMETERY OR CREMATORY Workmen Circle | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Sol Levinson & Bros. Inc., 6010 Reist., Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2064 | |
|---|---------------|--|------------------|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 2064 | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) ANNA FLEISHMAN | | February 26, 1967 12:45 PM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) 90 Jewish Convelesant Home 4601 Pall Mall Rd. | | A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3902 Hilton St Rd. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) 76 | 10. If Under 1 Yr. Months: Days: 11. If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Russia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Unknown | | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. No | | 17. INFORMANT ADDRESS Mr. Hyman Craven-- 3205 Smith Ave. #8 | | | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 163 X I Carcinoma of Lung | | 3 mo. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12:15, 1966 to 2:26, 1967, that (I) (we) lost saw the deceased alive on 2:26, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A.A. Silver | | | | 23B. DATE SIGNED 2.27.67 | |
| 23C. PHYSICIAN'S NAME (Type) XXXX A.A. SILVER | | | | 23D. ADDRESS M.D. 6210 Park Heights Ave. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 2/27/67 | | 24C. NAME OF CEMETERY or CREMATORY Section (Mishkon Israel) Bnai Israel/Baltimore, Maryland | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. MAR 1 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS INC. 6010 Reist Rd. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2065 | |
|---|-------------------------|--|---|--|--|
| BIRTH NO. 67 2065 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Carroll L. Boughan | | | | Feb. 26, 1967 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 D.O. A. St. Agnes Hosp. | | | | A. STATE Md. B. COUNTY Balto. Co | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Catonsville | |
| | | | | D. STREET ADDRESS (If rural, give location) 404 Wrenleigh Drive | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Oct. 20, 1902 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic. | | | 10B. KIND OF BUSINESS OR INDUSTRY Self Emp. | | 11. BIRTHPLACE (State or foreign country) Virginia |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 13. FATHER'S NAME Garland Boughan | | |
| 14. MOTHER'S MAIDEN NAME Estelle Elliott | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 218-32-2072 | | | 17. INFORMANT ADDRESS Catonsville, Md. 28 Mrs. Ella K. Boughan 404 Wrenleigh Drive | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) Massive Coronary Thrombosis (B) Coronary atherosclerosis (C) | |
| INTERVAL BETWEEN ONSET AND DEATH Instantaneous Unknown | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/21 1967 to 2/26 1967 , that (I) (we) last saw the deceased alive on 2/7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Cliff Ratliff Jr. | | | | 23B. DATE SIGNED 2/28/67 | |
| 23C. PHYSICIAN'S NAME (Type) CLIFF RATLIFF JR. | | | | 23D. ADDRESS 4405 EDMONDSON AVE # 27 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE March 1, 1967 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem. | |
| 24D. LOCATION Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR G. Truman Schwab | | | |
| 25D. ADDRESS 3512 Frederick Ave. Balto. Md. | | | | | |

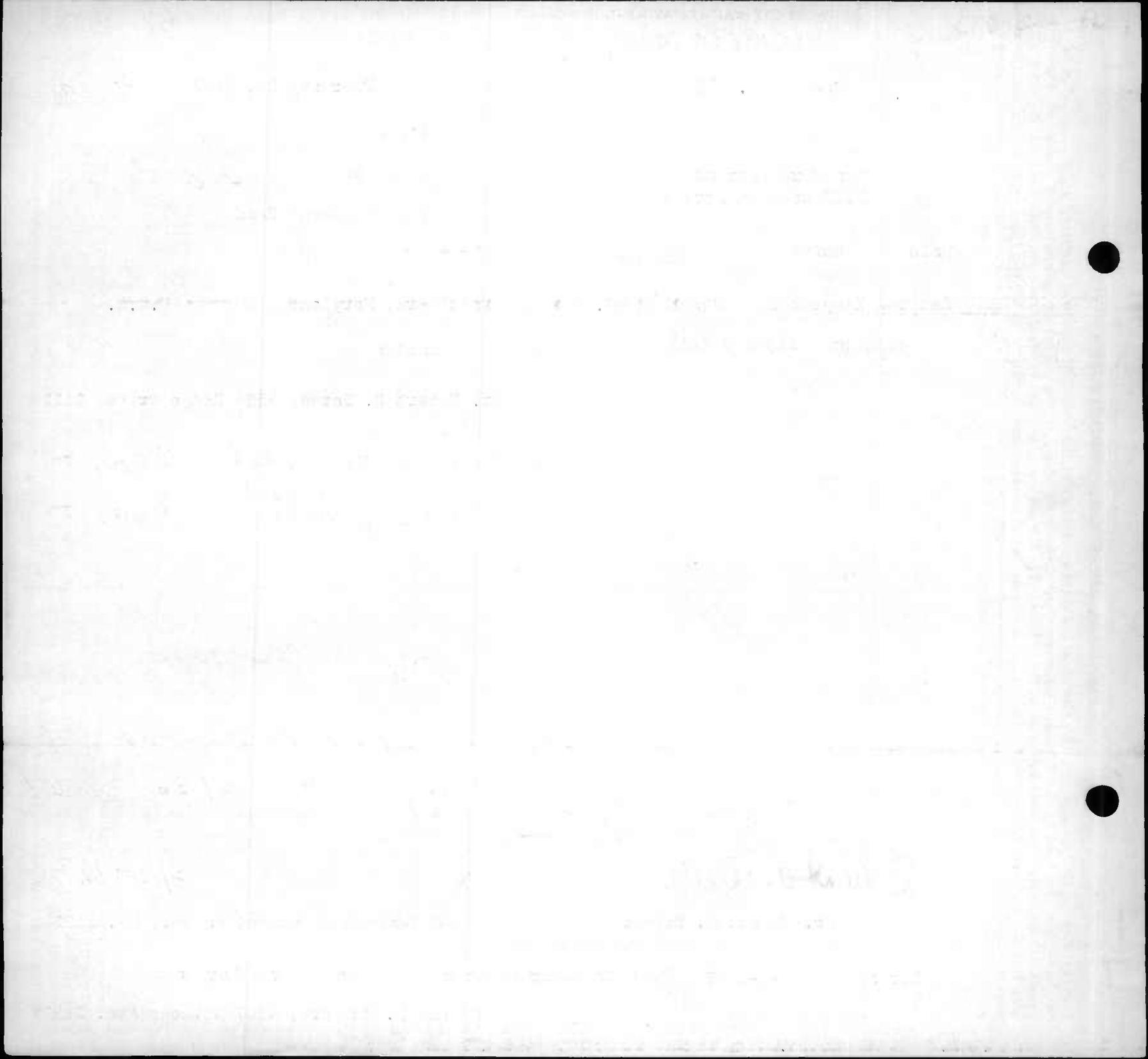
From New York
New York

29/11
Hos. Chapman

CLIFF BARRIE
New York

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. 67 2066 |
|---|------------------------------|--|-------------------------------------|---|
| BIRTH NO. 67 2066 | | | | |
| M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) GERALD M. BEIL | | 2. DATE AND HOUR OF DEATH February 26, 1967 4 a. m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 Crawford Retreat 2117 Denison Street | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | D. STREET ADDRESS (If rural, give location) 506 Kingston Road | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 9-8-1896 | 9. AGE (In years lost birthday) 70 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Inspector | | 10B. KIND OF BUSINESS OR INDUSTRY State of Md. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland |
| 13. FATHER'S NAME Alphonse Beil | | 14. MOTHER'S MAIDEN NAME Amelia | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. Robert E. Parks, 4524 Ridge Drive 21229 |
| 18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 3 yrs. + | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Cirrhosis of liver INTERVAL BETWEEN ONSET AND DEATH 3 yrs. + | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from 10/26 1964 to 2/26 1967 . that (I) (we) last saw the deceased alive on 2/24 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | |
| 23A. SIGNATURE Robert A. Reiter | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2/27/67 |
| 23C. PHYSICIAN'S NAME (Type) Dr. Robert A. Reiter | | 23D. ADDRESS 606 Edmondson Avenue, Balto., Md. 21228 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3-1-1967 | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR Robert E. Parks | | 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 2067

BIRTH NO. 67 03 632 2067

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

MARTIN BERNARD EUGENE JR. (Baby Boy A)

2. DATE AND HOUR OF DEATH

2-26-67 1:00 AM

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

42 SINAI HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

MD.

B. COUNTY

BALTO

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTO. MD. 53-00

D. STREET ADDRESS (If rural, give location)

7864 ST. FABIAN LANE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED

8. DATE OF BIRTH

2-19-67

9. AGE (In years last birthday)

If Under 1 Yr. Months: Days: Hours: Min. 7 6 00

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

BERNARD E. MARTIN

14. MOTHER'S MAIDEN NAME

JUDY D. SMALL

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

MERNARD E. MARTIN, 7864 ST. FABIAN LANE

ADDRESS

212

18. 773.51

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

marked hyp. disten

(B) DUE TO

Hyaline Membran Dis.

(C) DUE TO

Immaturity

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-19 19 67 to 2-26 19 67, that (I) (we) last saw the deceased alive on 2-26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Lucile A. Torrey

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

2-26-67

23C. PHYSICIAN'S NAME (Type)

Lucile A. Torrey

M.D.

23D. ADDRESS

SINAI Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

2/28/67

24C. NAME OF CEMETERY OR CREMATORY

BALTIMORE NATIONAL CEM.

24D. LOCATION

BALTO., MD.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 2 1967

25B. NAME OF REGISTRAR

Robert E. Fagley

25C. FUNERAL DIRECTOR

HOWARD H. HUBBARD

ADDRESS

4107 WILKENS AVE,

THE UNIVERSITY OF MICHIGAN LIBRARY

3000 ZEEB RD
ANN ARBOR MI 48106-1500
TEL 734 763 1000
FAX 734 763 1001

UNIVERSITY MICROFILMS
SERIALS ACQUISITION
300 N ZEEB RD
ANN ARBOR MI 48106-1500

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-4511

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|------------------|--|--------------------------------|--|--|
| BIRTH NO. 67 2068 | | CERTIFICATE OF DEATH | | 67 2068 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Philip Klompus | | 2. DATE AND HOUR OF DEATH FEB. 28, 1967 6:15 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION 2826 OAKLEY AVE | | D. STREET ADDRESS (If rural, give location) 2826 OAKLEY AVE | | E. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 10/14/1892 | 9. AGE (In years last birthday) 74 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY PAPERHANGER | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 13. FATHER'S NAME YANIE | | 14. MOTHER'S MAIDEN NAME BESSIE | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES I | | 16. SOCIAL SECURITY NO. 218-32-4957A | | 17. INFORMANT EVA KLOMPUS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) CARCINOMA OF THE BLADDER DUE TO (B) with generalized Metastasis DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 4 Mos. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Cardio Vase. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from November 1966 to 2-2-8-1967, that (I) (we) last saw the deceased alive on 2-28-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph Deckelbaum | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2-1-67 | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH DECKELBAUM | | 23D. ADDRESS M.D. 3502 WEST ROGERS AVE BALTO 21215 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/2/1967 | | 24C. NAME OF CEMETERY or CREMATORY ROSEDALE | |
| 24D. LOCATION (City, town, or county) (State) BALTO MD | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR SYLVAN S. LEWIS & SON - GARRISON, MD | |
| 25C. FUNERAL DIRECTOR SYLVAN S. LEWIS & SON - GARRISON, MD | | 25D. ADDRESS 2075 | | | |

Married
Baroness
Mrs. Carey Ave

Wife
Mrs. Carey Ave
Baroness

Baroness

Mrs. Carey Ave

Baroness
Mrs. Carey Ave

Baroness
Mrs. Carey Ave

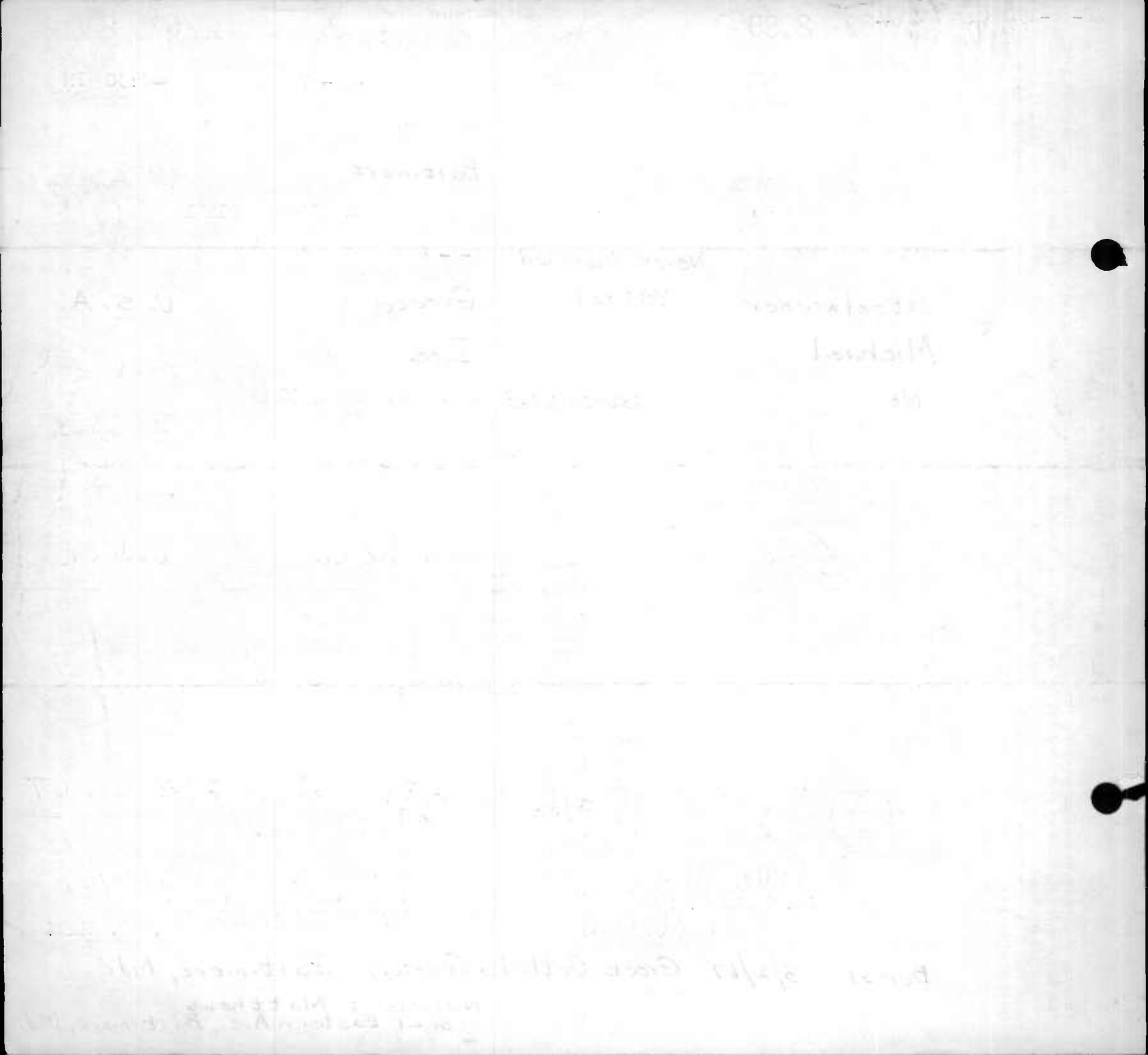
Baroness
Mrs. Carey Ave

Baroness
Mrs. Carey Ave

FUNERAL DIRECTOR: IMPORTANT

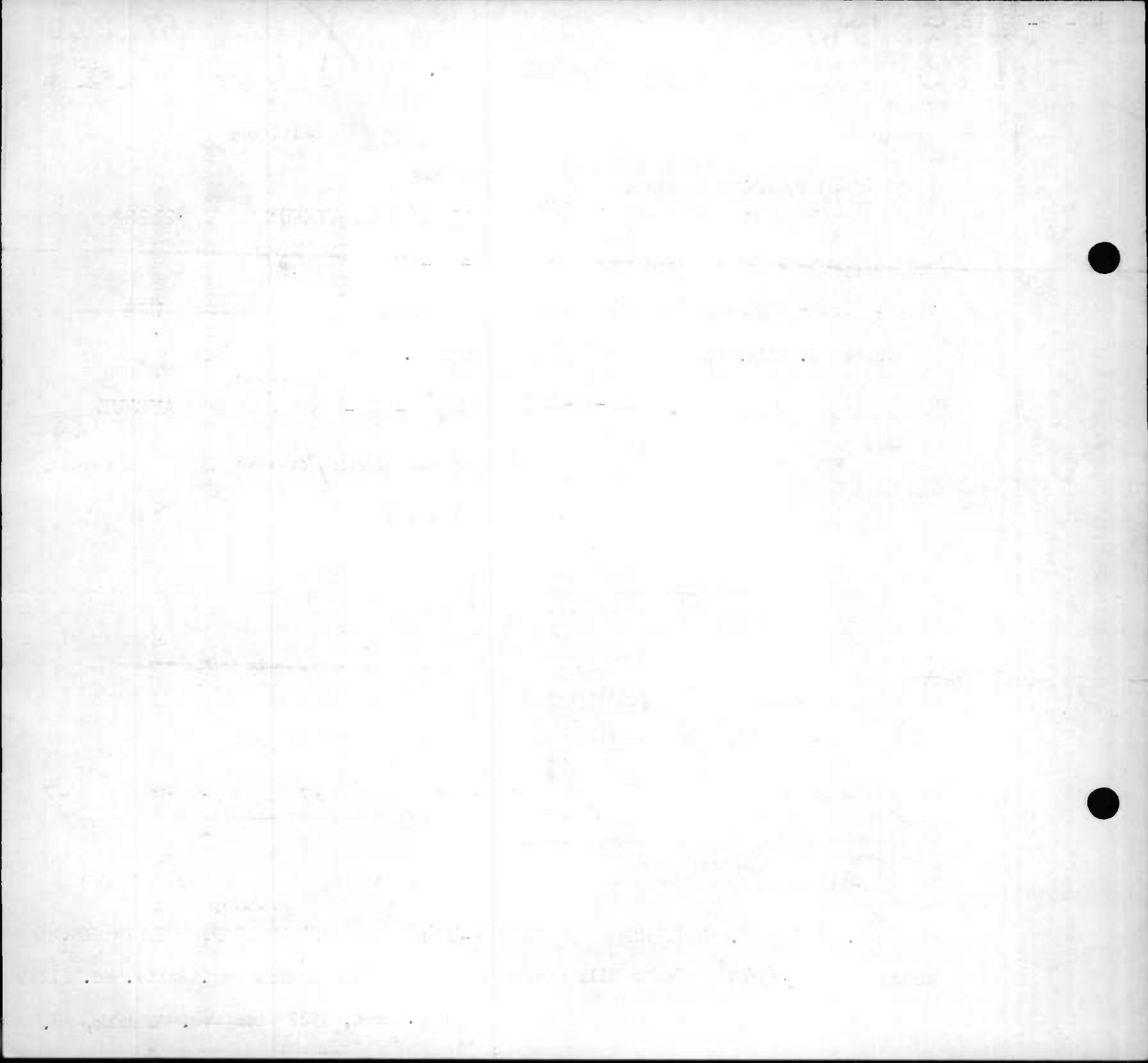
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|
| 48-66-29TN | | -432-67 2069 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 2069 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | | | JOHN CLADIAS | | 2-28-67 | | 4:30 PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | | | A. STATE MARYLAND B. COUNTY BALTO CO | | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | D. STREET ADDRESS (If rural, give location) 312 RIVERSIDE AVENUE 21221 | | | | | |
| 5. SEX MALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | | 8. DATE OF BIRTH 7-4-86 | | 9. AGE (In years lost birthday) 80 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker | | 10B. KIND OF BUSINESS OR INDUSTRY Steel | | 11. BIRTHPLACE (State or foreign country) Greece | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Michael | | | | 14. MOTHER'S MAIDEN NAME Zoe | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 236-03-5963 | | 17. INFORMANT BCH: RECORDS 4940 | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) I 137X I sepsis | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) ? pancreatic Ca | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days unknown | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/28 1967 to 2/28 1967. that (I) (we) last saw the deceased alive on 2/28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Bruce M. Dow | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/28/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) DR. BRUCE M. DOW | | | | 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTO. MD. 21224 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/67 | | 24C. NAME OF CEMETERY OR CREMATORY Greek Orthodox Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR Robert E. Stokely | | 25C. FUNERAL DIRECTOR Nicholas T. Matthews | | ADDRESS 2302 Eastern Ave., Baltimore, Md. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|-----------------------------|--|--|
| 48-72-121B E-465 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2070 | |
| BIRTH NO. 67 2070 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) EILERMAN FRED Fred Eilerman Sr. | | 2. DATE AND HOUR OF DEATH 2-28-67 2:55 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE 31 BALTIMORE, MARYLAND #21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Dundalk 53-00 | | | |
| D. STREET ADDRESS (If rural, give location) 113 CENTRE AVENUE #21222 | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 2-17-87 | 9. AGE (In years last birthday) 80 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Self-Employed Taxi Cab Owner | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Issac J. Eilerman | | 14. MOTHER'S MAIDEN NAME Maria E. Muth | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-32-8145 | | 17. INFORMANT #21224 RECORDS-BCH-4940 EASTERN AVENUE | |
| 18. 433.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Cardiac arrhythmia (B) DUE TO ASCVD (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 35 min 76 yrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2-17 1967 to 2-28 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2-28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James J. Corkins | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2-28-67 | |
| 23C. PHYSICIAN'S NAME (Type) DR. JAMES T. CORKINS | | 23D. ADDRESS #21224 BCH-4940 EASTERN AVENUE, BALTIMORE, MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/3/67 | | 24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| 24D. LOCATION (City, town, or county) (State) 5829 Ritchie Hwy. Balto. Md. 21225 | | 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | |
| 25C. FUNERAL DIRECTOR John J. Duda | | ADDRESS 7922 Wise Ave. Dundalk, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 2071 | | | |
|--|--|---|--|---|--|---|--|--|--|--|--|---|--|
| BIRTH NO. 67 2071 | | | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Joseph A. Dumbrowsky | | | | | 2. DATE AND HOUR OF DEATH 3/1/67 1:15 A.M. | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 48 GENERAL (If not in hospital or institution, give street address or location) | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE DUNDALK 53-00 D. STREET ADDRESS (If rural, give location) 7926 Dierkwood Pl 21222 | | | | | | | | |
| 5. SEX Male | | 6. RACE CAUCASIAN | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | | 8. DATE OF BIRTH 10/8/17 | | 9. AGE (In years last birthday) 49 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ADAM Dumbrowsky | | | | | 14. MOTHER'S MAIDEN NAME MARYLAND Catherine Kaphas | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II, Army | | | | | 16. SOCIAL SECURITY NO. 220-65-1806 | | 17. INFORMANT admission record | | | | | ADDRESS | |
| 18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) esophageal obstruction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARCINOMA of lung | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. pneumonitis | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION Feb 1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA - lung | | | 20A. AUTOPSY? (Yes or No) none | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., on or about home, farm, factory, street, office bldg., etc.) in car | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED while at work White <input checked="" type="checkbox"/> Non-White <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that the (this hospital) attended the deceased from 2/8 1967 to 3/1 1967, that we last saw the deceased alive on 3/1 1967 and that in our opinion death occurred on the date and hour and from the causes stated above. we (We) did not view the body after death. | | | | | | | | | | | | | |
| 23A. SIGNATURE Fred R. Eiber | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 3/1/67 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) FRED R. EIBER | | | | | 23D. ADDRESS MARYLAND General Hosp. | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 3-4-1967 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224 | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | 25C. FUNERAL DIRECTOR JOHN J. DUDA | | | ADDRESS Dundalk, Maryland 21222 | | | | |

January 1, 1968

Dear Mr. [Name]

I am writing to you regarding the [Subject]

which was discussed at the [Meeting]

on [Date].

I am sure that you will find this [Information]

of interest.

I am looking forward to hearing from you.

Sincerely,

[Signature]

[Name]

[Address]

[City, State, Zip]

[Phone Number]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2072 | |
|---|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. 67 2072 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) GRACE BARTLOW | | Feb. 24, 1967 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) 1500 CYPRESS STREET | | A. STATE MD. B. COUNTY BALTIMORE | | | |
| 00 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 1500 CYPRESS STREET | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 4 12 22 | 9. AGE (In years last birthday) 44 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 13. FATHER'S NAME John Riley | | 14. MOTHER'S MAIDEN NAME Mable Webster | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family | |
| 18. 416X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Embolus | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 1 hour | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO Rheumatic Heart Disease | | (B) DUE TO 10 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) _____ | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6/3/58 19 67 to 2/24 19 67 , that (I) (we) last saw the deceased alive on 2/20 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Benjamin Berdamm | | | | 23B. DATE SIGNED 2/25/67 | |
| 23C. PHYSICIAN'S NAME (Type) Benjamin Berdamm | | | | 23D. ADDRESS 5010 A Ritchie Hwy. Baltimore 21225 Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/1/67 | | 24C. NAME OF CEMETERY or CREMATORY Morgantown | |
| 24D. LOCATION Morgantown W. Va. | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Mc Gully | |
| | | | | 237 Patapasco Ave. | |

1 hour
Crested Auklet
Alaska West Coast 1972

4/1/72
4/2/72

4/3/72

4/4

John P. Johnson

Body released by medical examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2073 | |
|--|----------------------|--|-----------------------------------|--|---|
| BIRTH NO. 67 2073 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Leon W. Kowalski | | 2. DATE AND HOUR OF DEATH 3/1/67 7:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church home & hospital 108 W. Broadway Baltimore Md | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 35 Collington Ave | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH 4/13/1909 | 9. AGE (In years last birthday) 57 58 yrs | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker | | 10B. KIND OF BUSINESS OR INDUSTRY Baking | | 11. BIRTH PLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John Kowalski JOHN KOWALSKI | | | |
| 14. MOTHER'S MAIDEN NAME Anna Dlugolenski ANNA DLUGOLENSKI | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No Unknown | | | |
| 16. SOCIAL SECURITY NO. 217-32-9307 | | 17. INFORMANT Miss Jennie Kowalski SISTER 3.5. Collington Ave | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (A) Cirrhosis of liver | | INTERVAL BETWEEN ONSET AND DEATH not known | |
| (B) Acute pulmonary edema | | (C) | | 3/1/67 | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/28 19 67 to 3/1 19 67 , that (I) (we) last saw the deceased alive on 3/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE K.M. Anandah | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/1/67 | |
| 23C. PHYSICIAN'S NAME (Type) K.M. ANANDAH | | 23D. ADDRESS Church home & hospital Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/4/67 | | 24C. NAME OF CEMETERY or CREMATORY Holy Rosary | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | | |
| 25B. NAME OF REGISTRAR M.F. SADOWSKI & SONS | | 25C. FUNERAL DIRECTOR ADDRESS 1808 EASTERN AVE | | | |

✓ KOWALSKI, M. W.

Chronic bronchitis & asthma
Baltimore, Md. formerly

Male White Divorced

Unknown

11/13/1903 28 yrs
Columbia, Md.
Baltimore
Maryland

7.30 A

3/1/03

Arts following above
3/1/03

no

3/1

2/18/03

3/1

2/1

K.M. Anderson
K.M. Anderson

3/1/03
Chronic bronchitis & asthma
Baltimore

1

67 2074

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2074

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)WESLEY
CARLTON / TIMMONS

2. DATE AND HOUR PRONOUNCED DEAD

February 26, 1967 12:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital (DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland Wicomico

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Salisbury

D. STREET ADDRESS (If rural, give location)

411 Barclay Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

February 28, 1922

9. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11 28

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Electrician - Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Salisbury, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Morris Timmons

14. MOTHER'S MAIDEN NAME

Roxie Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

War II

16. SOCIAL
SECURITY NO.

222-14-6649

17. INFORMANT

Mrs. Eva Mae Knapp (Sister) 318 Carey Ave.
Salisbury, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Lobar pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

(Partial)

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

Partial

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

February 26, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/1/67

23C. NAME OF CEMETERY or CREMATORY

Parsons Cemetery

23D. LOCATION

(City, town, or county)

Salisbury, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

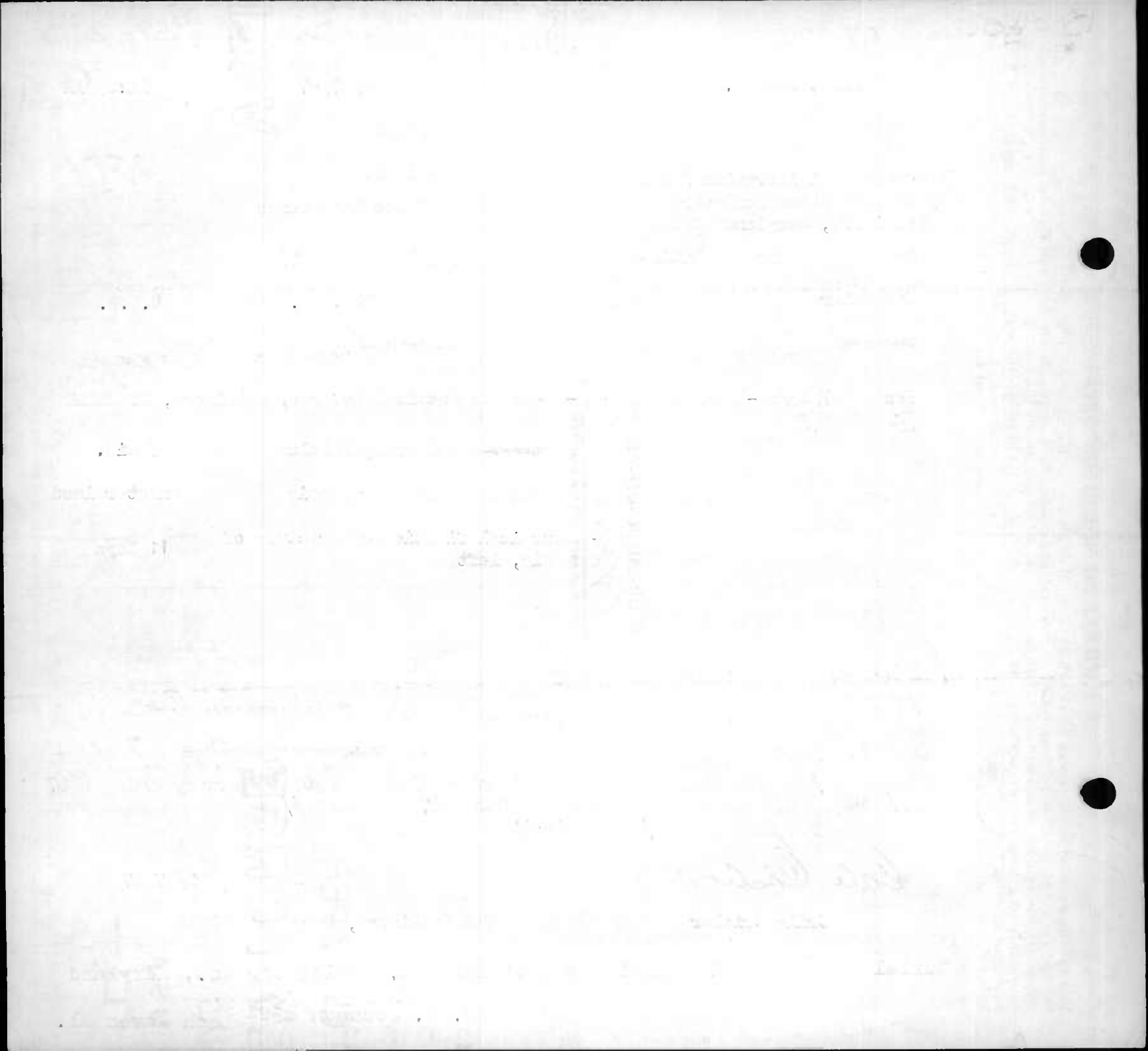
HOLLOWAY & COMPANY, SALISBURY, MARYLAND

WALKLEY HONGRE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2075 | |
|---|--|--|--|--|--|
| BIRTH NO. 67 2075 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) BAER, Fred I. | | 2. DATE AND HOUR OF DEATH 2/27/67 12:05 AM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-01 | | | |
| D. STREET ADDRESS 4007 Woodlea Avenue | | 5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single WIDOWED | | | |
| 8. DATE OF BIRTH 8/15/1890 | | 9. AGE (In years last birthday) 76 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | |
| 11. BIRTHPLACE (State or foreign country) Kansas City, Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME unknown JACOB BAER | |
| 14. MOTHER'S MAIDEN NAME unknown CAROLINE MEYER | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 7/15/18-1/23/19 | | 16. SOCIAL SECURITY NO. 212-15-64-68 | |
| 17. INFORMANT VA Hospital Records, Baltimore, Md 21218 | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Possible Pulmonary Embolus Possible Venous Thrombosis Surgical fixation of Fracture of hip, left | | INTERVAL BETWEEN ONSET AND DEATH 5 Min. Undetermined 11 Days | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 20. AUTOPSY? (Yes or No) NO | | 21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 22. I certify that (I) (this hospital) attended the deceased from February 13th 19 67 to February 27th 19 67, that (I) (we) last saw the deceased alive on February 27th 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Crile Crisler, M.D. | | 23B. DATE SIGNED 2/27/67 | |
| 23C. PHYSICIAN'S NAME (Type) Crile Crisler | | 23D. ADDRESS VAH Baltimore, Maryland 21218 | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 24B. DATE 3/1/67 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR Wm. E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS 8521 Loch Raven Bl. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

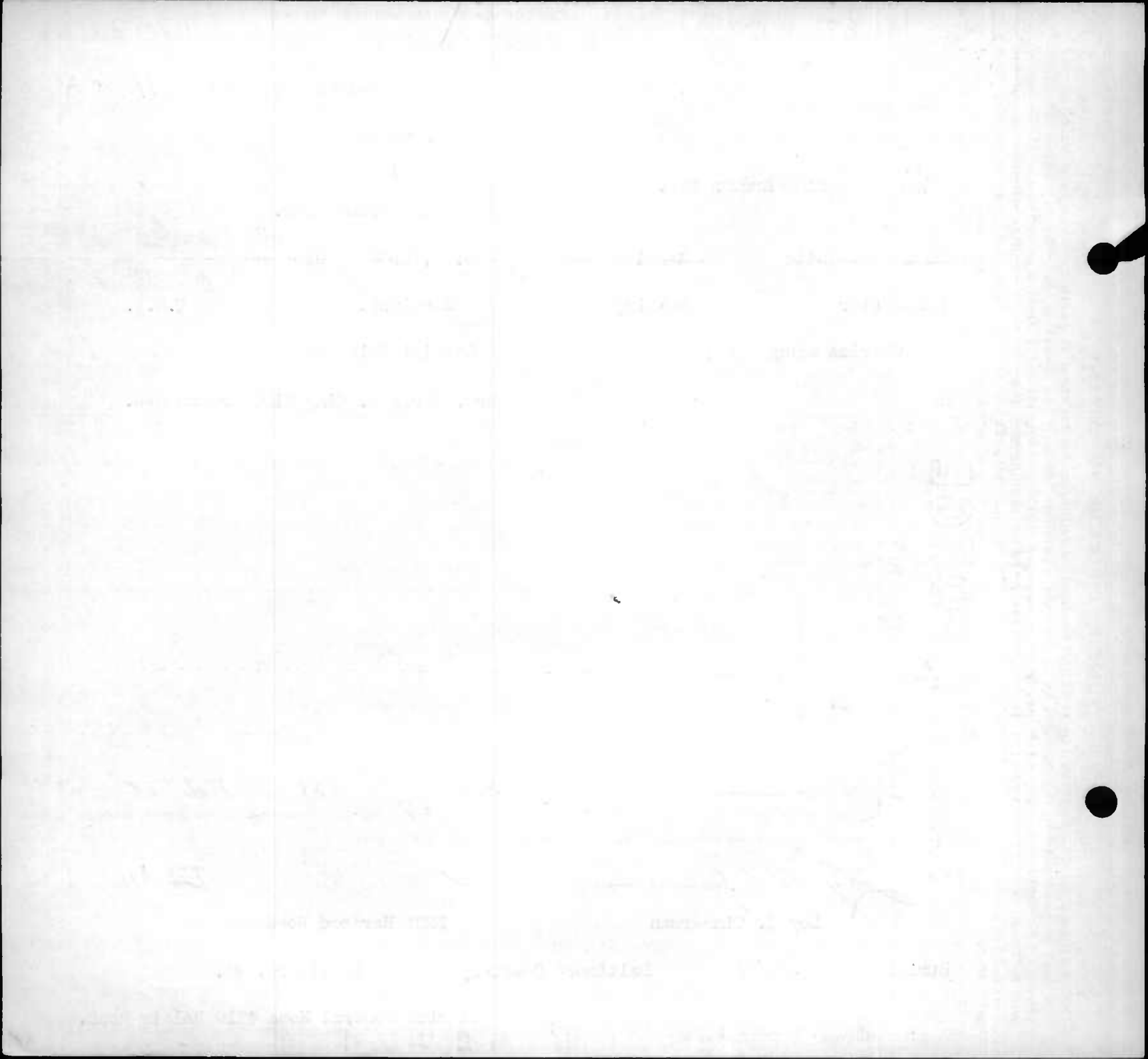
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2076 | |
|---|-----------|--|--|--|-------------------------------------|
| BIRTH NO. 67 2076 | | CERTIFICATE OF DEATH | | Registered No. 67 2076 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Proctor, Elizabeth Ada | | 2. DATE AND HOUR OF DEATH 2/19/67 8:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 91 Montebello | | A. STATE Maryland, Charles Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pomfret, Maryland D. STREET ADDRESS (If rural, give location) 58-00 | | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 3-22-1904 | 9. AGE (In years, last birthday) 63 | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) George Butler | | 10B. KIND OF BUSINESS OR INDUSTRY House wife | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME Charles, County, Maryland | | 17. INFORMANT ADDRESS William Mar | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Renal failure DUE TO (B) Diabetes mellitus DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 yr 11 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 30 Jan 1967 to 2/19 1967, that (I) (we) last saw the deceased alive on 2/19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert W. Ireland M.O. | | 23B. DATE SIGNED 2/19/67 | | 23C. PHYSICIAN'S NAME (Type) Robert W. Ireland M.O. | |
| 23D. ADDRESS Montebello State Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-22-67 | | 24C. NAME OF CEMETERY OR CREMATORY St. Joseph Ch. Cem. Pomfret, Md. | |
| 24D. LOCATION (City, town, or county) (State) Pomfret, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Keith E. O'Neil | | 25D. ADDRESS Gary E. O'Neil | | | |

Robert A. Ireland

Robert A. Ireland

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2077 | |
|---|-------------------------|---|---|--|---|
| BIRTH NO. 67 2077 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) George W. King, | | 2. DATE AND HOUR OF DEATH February 28, 1967 11:30 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2103 Erdman Ave. | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2103 Erdman Ave. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Oct. 6, 1885 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor | | 10B. KIND OF BUSINESS OR INDUSTRY Heating | | 11. BIRTHPLACE (State or foreign country) Maryland. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Charles King | | 14. MOTHER'S MAIDEN NAME Harriet Thierkel | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Marie E. King 2103 Erdman Ave. | |
| 18. 450.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized Atherosclerosis | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH Several Years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1966 to Feb 28 1967 , that (I) (we) last saw the deceased alive on Feb 21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Loy M. Zimmerman | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED March 1, 67 | |
| 23C. PHYSICIAN'S NAME (Type) Loy M. Zimmerman | | 23D. ADDRESS 3202 Harford Road | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/3/67 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Charles E. Jackson | | 25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 4210 Belair Road. | |



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L-100

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. **67 2078** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 2078**

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **Clarence J. LAIB** 2. DATE AND HOUR PRONOUNCED DEAD **February 26, 1967 6:15 A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
00 502 W. Fayette Street **Baltimore**

D. STREET ADDRESS (If rural, give location) **502 W. Fayette Street (Caroline Hotel)**

5. SEX **Male** 6. RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Single** 8. DATE OF BIRTH **1893 ?** 9. AGE (In years last birthday) **XX 73 ?** 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None** 11. BIRTHPLACE (State or foreign country) **Maryland.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Edward J. Laib** 14. MOTHER'S MAIDEN NAME **Alice J. ?**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT **J. Calvin Carney, Jr. Charles & Lexington Sts.** ADDRESS

18. **420.0** CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) **Arteriosclerotic heart disease**

19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)

20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

21. DATE OF OPERATION 22. CONDITION FOR WHICH OPERATION WAS PERFORMED 23. AUTOPSY? (Yes or No) **No** 24. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

25. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

28. TIME OF INJURY (Month) (Day) (Year) (Hour) 29. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 30. HOW DID INJURY OCCUR?

31. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

32. ACTUAL SIGNATURE **Charles S. Springate** M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **February 26, 1967**

EXAMINER'S NAME (Type) **Charles S. Springate, M.D.** ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **3/1/67** 23C. NAME OF CEMETERY or CREMATORY **Loudon Park Cemetery** 23D. LOCATION (City, town, or county) (State) **Baltimore, Md.**

24A. DATE REC'D BY HEALTH DEPT. **MAR 2 1967** 24B. NAME OF REGISTRAR **R. E. Fairbank** 24C. FUNERAL DIRECTOR **Ullrich Funeral Home** ADDRESS **4210 Belair Road.**

VS 151-REV. 1/1/65

VALLEY FORCE

VALLEY FORCE

VALLEY FORCE

VALLEY FORCE

VALLEY FORCE

VALLEY FORCE

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VALLEY FORCE

VALLEY FORCE

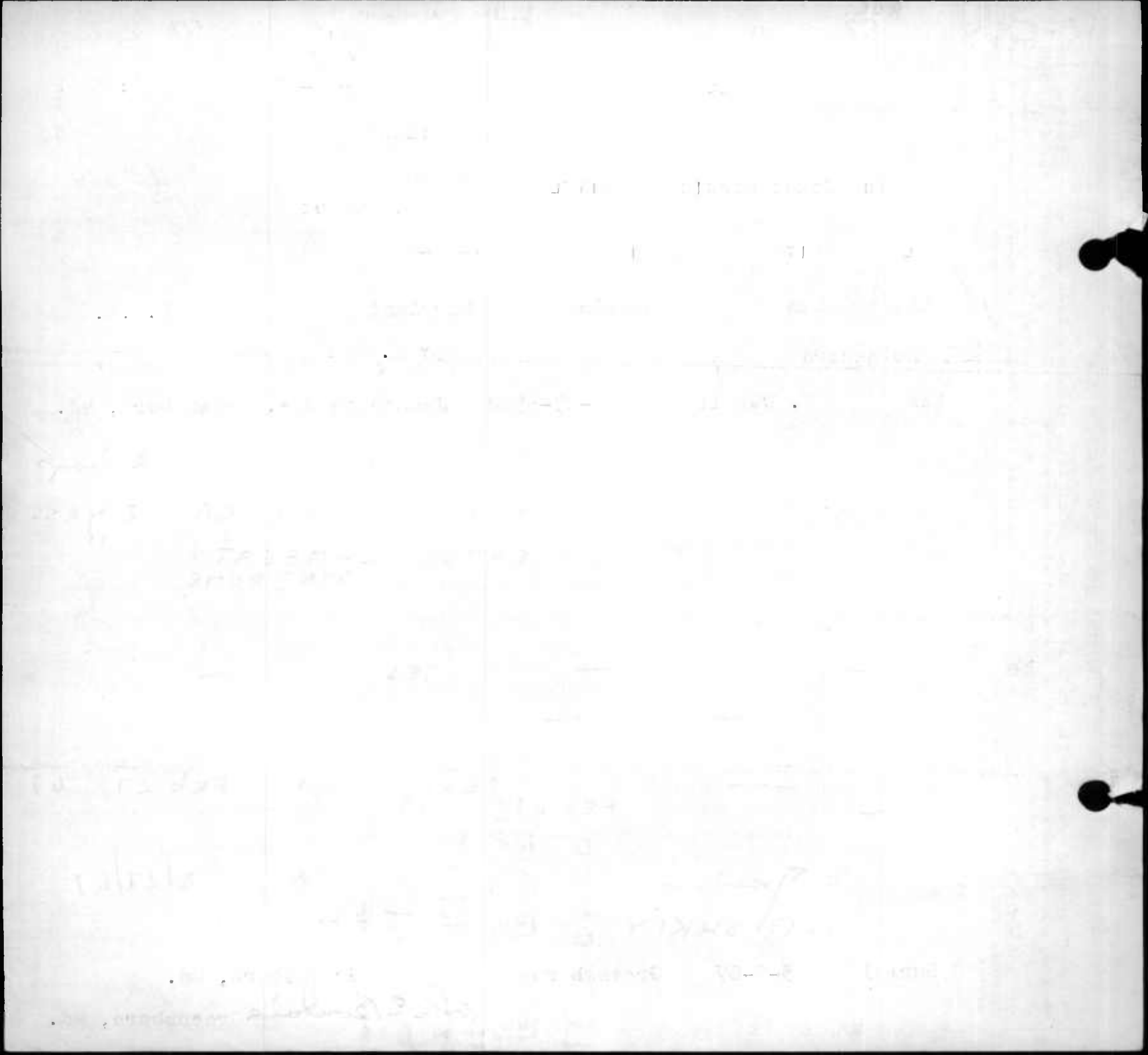
VALLEY FORCE

VALLEY FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

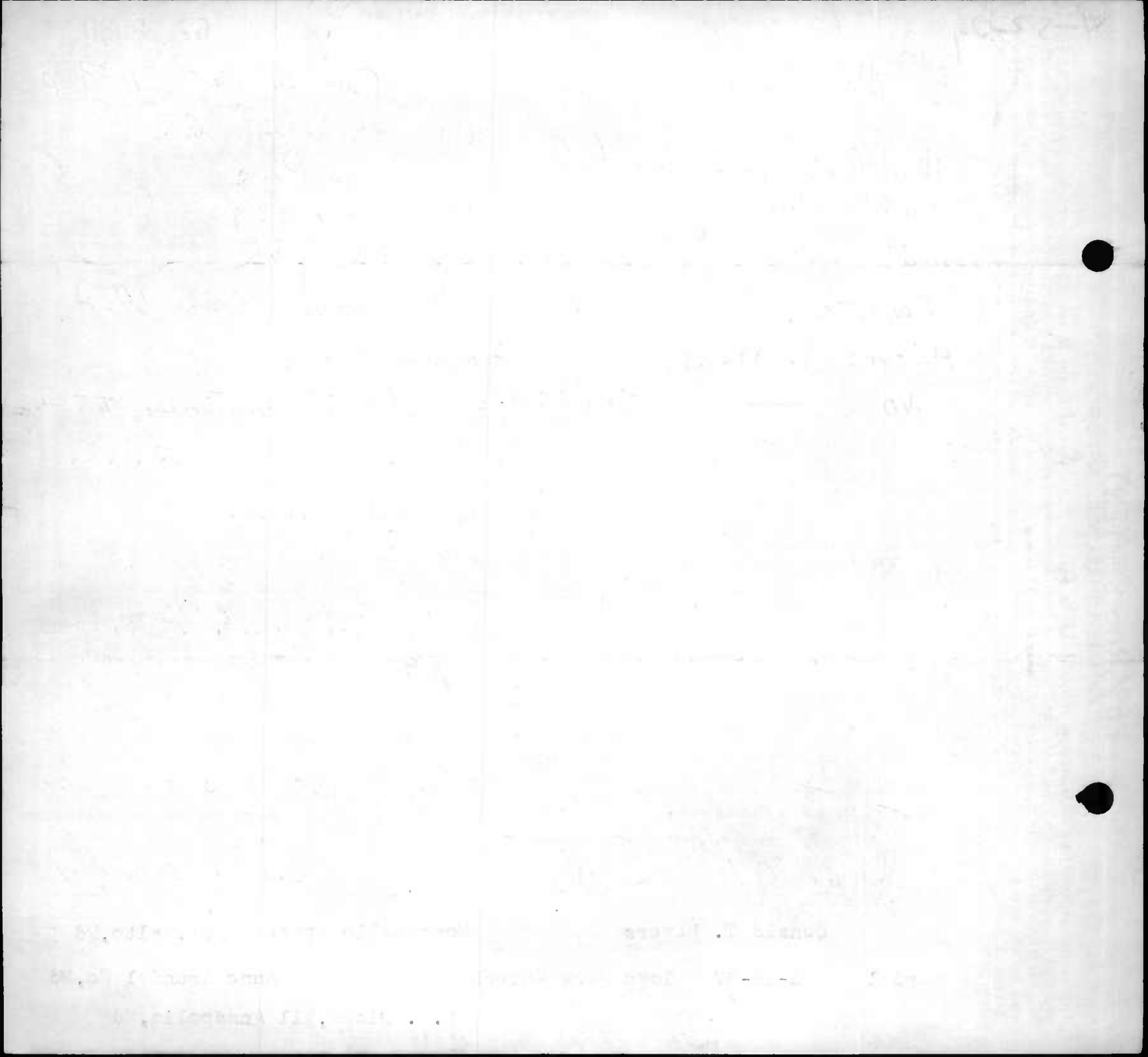
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2079 | |
|---|-------------------------|---|------------------------------------|--|--|
| BIRTH NO. 67 2079 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| MARSHALL ROE | | 2-27-67 4:45 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL | | A. STATE MARYLAND B. COUNTY Caroline Co | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) GREENSBORO | | | |
| | | D. STREET ADDRESS (If rural, give location) SUNSET AVENUE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4-16-13 | 9. AGE (In years lost birthday) 53 | 10. IF Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | | 10B. KIND OF BUSINESS OR INDUSTRY Electrical | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME No Record | | 14. MOTHER'S MAIDEN NAME MARY E. ROE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W. War 11 | | 16. SOCIAL SECURITY NO. 162-03-8502 | | 17. INFORMANT Jeannette Roe, Greensboro, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO BRONCHOGENIC CA | | 2 yrs | |
| | | (C) DUE TO EATON LAMBERT SYNDROME | | " | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) — | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that (I) (this hospital) attended the deceased from FEB 1 19 67 to FEB 27 19 67 , that (I) (we) last saw the deceased alive on FEB 27 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. P. Shkin | | | | 23B. DATE SIGNED 2/27/67 | |
| 23C. PHYSICIAN'S NAME (Type) S. P. SHKIN | | | | 23D. ADDRESS IHH | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-2-67 | | 24C. NAME OF CEMETERY or CREMATORY Greensboro | |
| 24D. LOCATION Greensboro, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | | |
| 25B. NAME OF REGISTRAR John E. Boudais | | 25C. FUNERAL DIRECTOR John E. Boudais | | | |
| 25D. ADDRESS Greensboro, Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

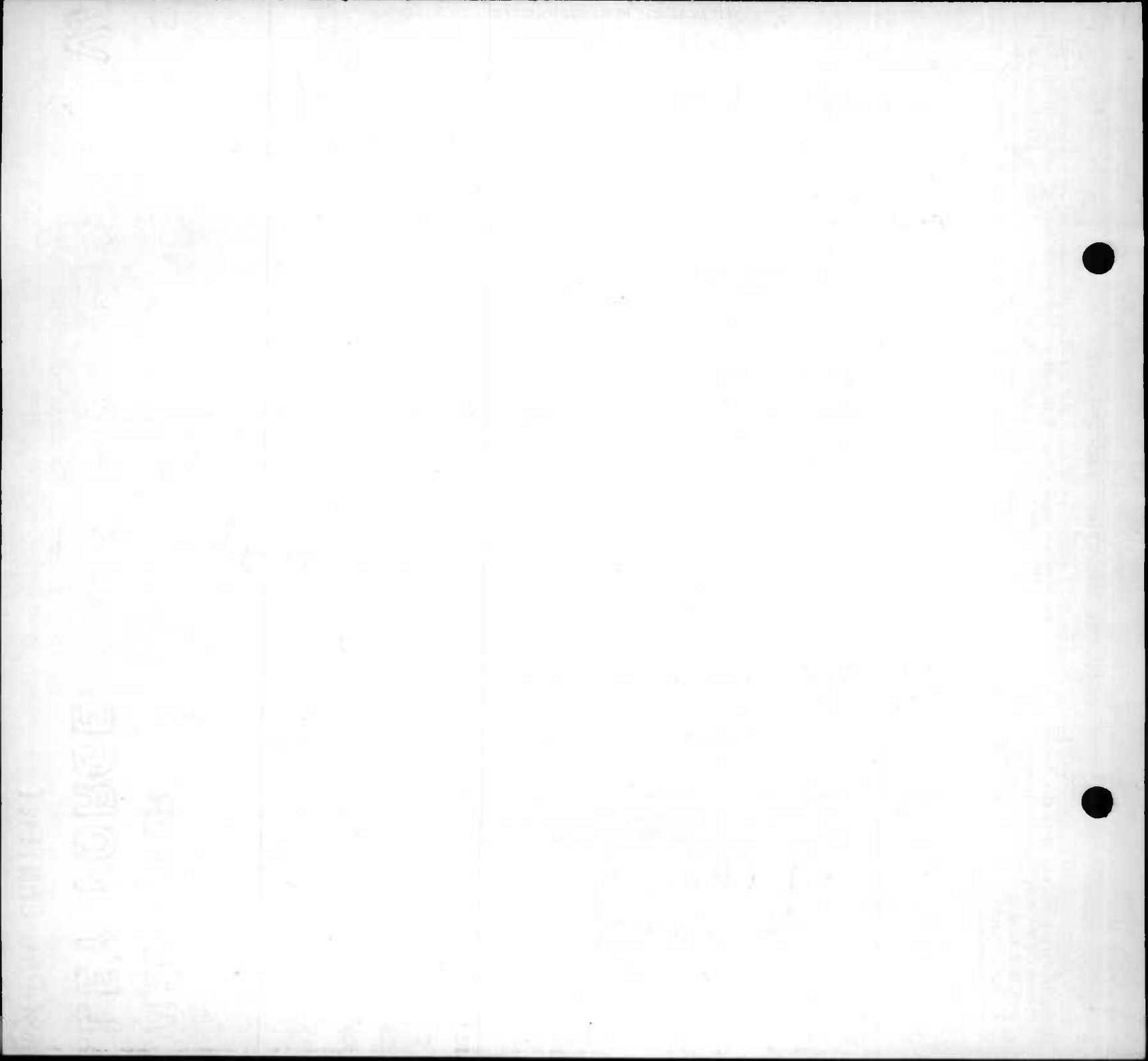
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2080 | |
|--|---------------------|--|------------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 2080 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>MARY MARGARET Young</i> | | 2. DATE AND HOUR OF DEATH <i>Feb 24, 1967, 11³⁰ P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Anne Arundel Co</i> | | | |
| FULL NAME OF HOSPITAL (OR INSTITUTION) (If not in hospital or institution, give street address or location) <i>Montebello State Hospital Balto Md.</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Severna Park 52-00</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>RT #1 Box 339</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>N</i> | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>9-30-89</i> | 9. AGE (In years lost birthday) <i>77</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>AL Fred J. MANNS</i> | | 14. MOTHER'S MAIDEN NAME <i>EMMA CURRY</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216-09-5345B</i> | | 17. INFORMANT <i>Chant Montebello State Hosp</i> | |
| 18. <i>600.0 I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Septicemia</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>Chronic Renal Failure</i> | | | |
| | | (C) <i>Probable Pyelonephritis</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <i>Arteriosclerotic Cardiovascular Disease</i> | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>2/14</i> 19 <i>67</i> to <i>2/24</i> 19 <i>67</i> , that (1) (we) last saw the deceased alive on <i>2/24</i> 19 <i>67</i> and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Donald T. Lewers MD</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>2/24/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Donald T. Lewers</i> | | 23D. ADDRESS M.D. <i>Montebello State Hospt, Balto, Md</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify). <i>Burial</i> | | 24B. DATE <i>2-28-67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Town Neck Church</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Anne Arundel Co, Md</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 2 1967</i> | | 25B. NAME OF REGISTRAR <i>Phyllis E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>C.E. Hicks, 111 Annapolis, Md</i> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2081 | |
|--|--|--|---|--|---|
| BIRTH NO. 07 2081 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Mary E. Ferguson</u> | | | 2. DATE AND HOUR OF DEATH <u>2/28/67</u> <u>7</u> <u>P.</u> M. | | |
| 3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>25-52</u> D. STREET ADDRESS (If rural, give location) <u>1104 Cherry Hill Rd. Apt K-25</u> | | |
| 5. SEX <u>Female</u> | | 6. RACE <u>Colored</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Divorced</u> | 8. DATE OF BIRTH <u>4/24/29</u> | 9. AGE (In years last birthday) <u>36</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Ga.</u> | |
| 13. FATHER'S NAME <u>Sam Ferguson</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mamie Davis</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>415485367</u> | | 17. INFORMANT <u>MATTIE GAINES</u> ADDRESS <u>1104 Cherry Hill Rd.</u> | |
| 18. <u>330X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <u>Subarachnoid hemorrhage days</u> (B) <u>Ruptured @ Internal</u> (C) <u>Cerebral aneurysm days</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION <u>2/25/67</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>To locate the aneurysm</u> | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>No</u> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>2-23-67</u> 19 to <u>2-28-67</u> 19, that (2) (we) last saw the deceased alive on <u>2-28-67</u> 19 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Rifat Abouy</u> | | | | 23B. DATE SIGNED <u>2-28-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Rifat Abouy</u> | | | | 23D. ADDRESS M.D. <u>S.B.F.H.</u> <u>1213 Light St.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3-3-67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>ARBUTUS MEM. PK.</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>ARBUTUS, MARYLAND</u> | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>Robert E. Ferguson</u> | |
| 25C. FUNERAL DIRECTOR <u>KEESON FUNERAL HOME</u> | | 25D. ADDRESS <u>1348 CALHOUN ST.</u> | | VS 150-REV. 1/11 | |



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T-512

| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|---|--------------------|---|--|
| BIRTH NO. 67 2082 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2082 | |
| M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| Gertrude Thompson | | 2/27/67 7:00 p. m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 1107 Stockton St. | | A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 16-01 D. STREET ADDRESS (If rural, give location) 1107 Stockton St. | |
| 5. SEX female | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 4-21-90 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 76 |
| 13. FATHER'S NAME Lewis Porter | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 11. BIRTHPLACE (State or foreign country) West Virginia |
| | | 17. INFORMANT Viola Thompson | 14. MOTHER'S MAIDEN NAME Comelia |
| | | ADDRESS 449 Roundview Rd. | |
| 18. CAUSE OF DEATH | | | |
| I 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO | | | |
| (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary emphysema | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) no |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED 2/28/67 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 3-4-67 | 23C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 24B. NAME OF REGISTRAR Charles E. Fisher, M.D. | 24C. FUNERAL DIRECTOR Kelson Funeral Home - 1348 Calhoun Street |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 24E. ADDRESS | |

WALTER
GALTBY
FORGOTTEN
AND
RECOVERED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ESTHER

HORNE

2. DATE AND HOUR PRONOUNCED DEAD

February 27, 1967

12:59 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 1110 Somerset Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1110 Somerset St.

5. SEX

Male F

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Aug. 7. 1921

9. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

DOMESTIC

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO. Md

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Eddie R. HORNE 1110 Somerset St

18. 174 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of Uterus
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m. WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

ASSISTANT MEDICAL EXAMINER ☒EXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

2/27/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

3-4-67

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

A. D. County, Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 2 1967

24B. NAME OF REGISTRAR

Robert E. Fidler, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Joseph S. Lockard 1304 N. Central Ave

July 7, 1921

Dr. J. H. ...

Domestic

No.

Division of ...

Received 3-4-21 Mr. ...
J. H. ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------|--|---|---|---|
| BIRTH NO. 61067 2084 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67. 2084 | |
| M.E. CASE NO. 485793 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) FARBO OR FORAB JOSEPH | | | 2. DATE AND HOUR OF DEATH 2/26/67 9.05 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO? D. STREET ADDRESS (If rural, give location) 317 EAST ST. | | |
| 5. SEX M. | 6. RACE W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 3/19/81 | 9. AGE (In years last birthday) 85 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER | | | 11. BIRTHPLACE (State or foreign country) ITALY | | 12. CITIZEN OF WHAT COUNTRY? ITALY |
| 13. FATHER'S NAME SALVATORE FARBO | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 235 07-0660 | | |
| 17. INFORMANT ADDRESS MRS. LOUISE MARINO 6918 DEL VALE PLACE | | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCT? or pulm. embol. < 5 min | | |
| 19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) H + ASCVD | | | 20. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Meningitis 2° to frontal skull fx | | | 22. I certify that (I) (this hospital) attended the deceased from 1/25 1967 to 2/26 1967, that (I) (we) last saw the deceased alive on 2/26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | |
| 23A. SIGNATURE ANN SILVER | | | 23B. DATE SIGNED 2/27/67 | | |
| 23C. PHYSICIAN'S NAME (Type) ANN SILVER | | | 23D. ADDRESS BALTO. CITY HOS. 4940 EASTERN AVE BALTO. Md. 21224 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/2/67 | | 24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER | |
| 24D. LOCATION BELAIR RD. BALTO. Md. | | 24E. LOCATION (City, town, or county) (State) | | 24F. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR J. B. E. Farbo | | 25C. FUNERAL DIRECTOR J. Della Noce 322 S. HIGH ST. | |

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G-650

67 2085

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2085

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ARTHUR W. GREEN

2. DATE AND HOUR PRONOUNCED DEAD

February 25, 1967 6:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)36
99 Franklin Square Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

8. DATE OF BIRTH

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

491X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bilateral bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic heart disease

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

February 26, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 67 2086 | |
|---|---------------|--|----------------------------|--|--|--|--|
| BIRTH NO. 455 67 2086 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Rachael Holloman Rachel Hallmon | | 2. DATE AND HOUR OF DEATH February 23, 1967 8:00 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | A. STATE Maryland B. COUNTY Anne Arundel C. CITY OR TOWN (If outside city limits, write RURAL and give township) Severn RURAL 52-00 D. STREET ADDRESS (If rural, give location) Box #142 21144 | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 4/20/1893 | 9. AGE (In years last birthday) 93 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 220-16-5187-T | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH (A) Carcinoma of the cervix DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/23 1966 to 2/23 1967, that (I) (we) lost saw the deceased alive on 2/23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | 23A. SIGNATURE Bruce M. Dow M.D. | | 23B. DATE SIGNED 2/23/67 | |
| 23C. PHYSICIAN'S NAME (Type) BRUCE M. DOW | | | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2/27/67 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial | | 24D. LOCATION (City, town, or county) (State) Baltimore MD | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR Robert E. Saker, M.D. | | 25C. FUNERAL DIRECTOR | | ADDRESS 1727 N. Me. | |

Commission of the service

9/02

BRUCE M. DON
BRUCE M. DON

9/02

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P-534

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. **67 2087** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 2087**

M.E. CASE NO.

| | | | | | |
|---|------------------|---|--------------------------------------|--|---|
| 1. NAME OF DECEASED (Type or Print) | | JAMES <u>Pendleton</u> PENDELTON | | 2. DATE AND HOUR PRONOUNCED DEAD February 25, 1967 4:30 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>34</u> <u>99</u> Bon Secour Hospital (DOA) | | A. STATE Maryland | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore <u>20-01</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) 1922 Lauretta Avenue | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>11-7-1904</u> | 9. AGE (In years last birthday) 62 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| <u>Club</u> | | | | <u>Washington, D.C.</u> | |
| 13. FATHER'S NAME <u>Henry Pendleton</u> | | 14. MOTHER'S MAIDEN NAME <u>Gertrude Gaston</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give why or dates of service) | | 16. SOCIAL SECURITY NO. <u>212-03-0456</u> | | 17. INFORMANT ADDRESS <u>Virginia Pendleton Same</u> | |
| 18. <u>420.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) <u>Arteriosclerotic heart disease</u> DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (B) _____ DUE TO | | | |
| | | (C) _____ | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Charles S. Springate</u> EXAMINER'S NAME (Type) | | Charles S. Springate, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23B. DATE <u>3/2/67</u> | | 23C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial</u> | |
| 24A. DATE REC'D BY HEALTH DEPT. <u>MAR 2 1967</u> | | 24B. NAME OF REGISTRAR <u>Robert E. Farber, MA</u> | | 24C. FUNERAL DIRECTOR <u>Whington Phillips</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore MD.</u> | |
| | | | | ADDRESS <u>1727 N. Mount St.</u> | |

19670002094

11-7-1914
Washington
D.C.
Mr. [illegible]
[illegible]
[illegible]

RECEIVED
FBI
NOV 10 1914

3/10/15
[illegible]

CERTIFICATE OF DEATH

Registered No. 67 2088

BIRTH NO. 67 2088

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

LOUIS JARVIS

2. DATE AND HOUR OF DEATH

1 March 1967 1 510 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

31 BALTIMORE CITY HOSPITALS
4940 Eastern Ave.
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1609 N. BRADFORD ST.

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

5 OCT 1902

9. AGE (In years
last birthday)

64

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CONSTRUCTION

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

ORRIS OLDS

14. MOTHER'S MAIDEN NAME

FRANCES JARVIS

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

#21224

BCH: Records 4940 Eastern Ave. Baltimore, Md.

18.

157X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Carcinoma of Pancreas
DUE TO with G.I. Bleeding

1 Year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Anemia, Dehydration, Malnutrition

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1 Jan 1967 to 1 March 1967,
that (I) (we) last saw the deceased alive on March 1 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Alan J. Barnes

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

1 March 1967

23C. PHYSICIAN'S
NAME (Type)

Alan J. Barnes

M.D.

23D. ADDRESS

Baltimore City Hospitals #21224
4940 Eastern Ave. Baltimore, Maryland24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3-4-67

24C. NAME of CEMETERY or CREMATORY

Joshburg Cem.

24D. LOCATION

Elizabeth City

NE

25A. DATE REC'D BY HEALTH DEPT.

MAR 2 1967

25B. NAME OF REGISTRAR

Robert E. Farley

25C. FUNERAL DIRECTOR

Everett Funeral

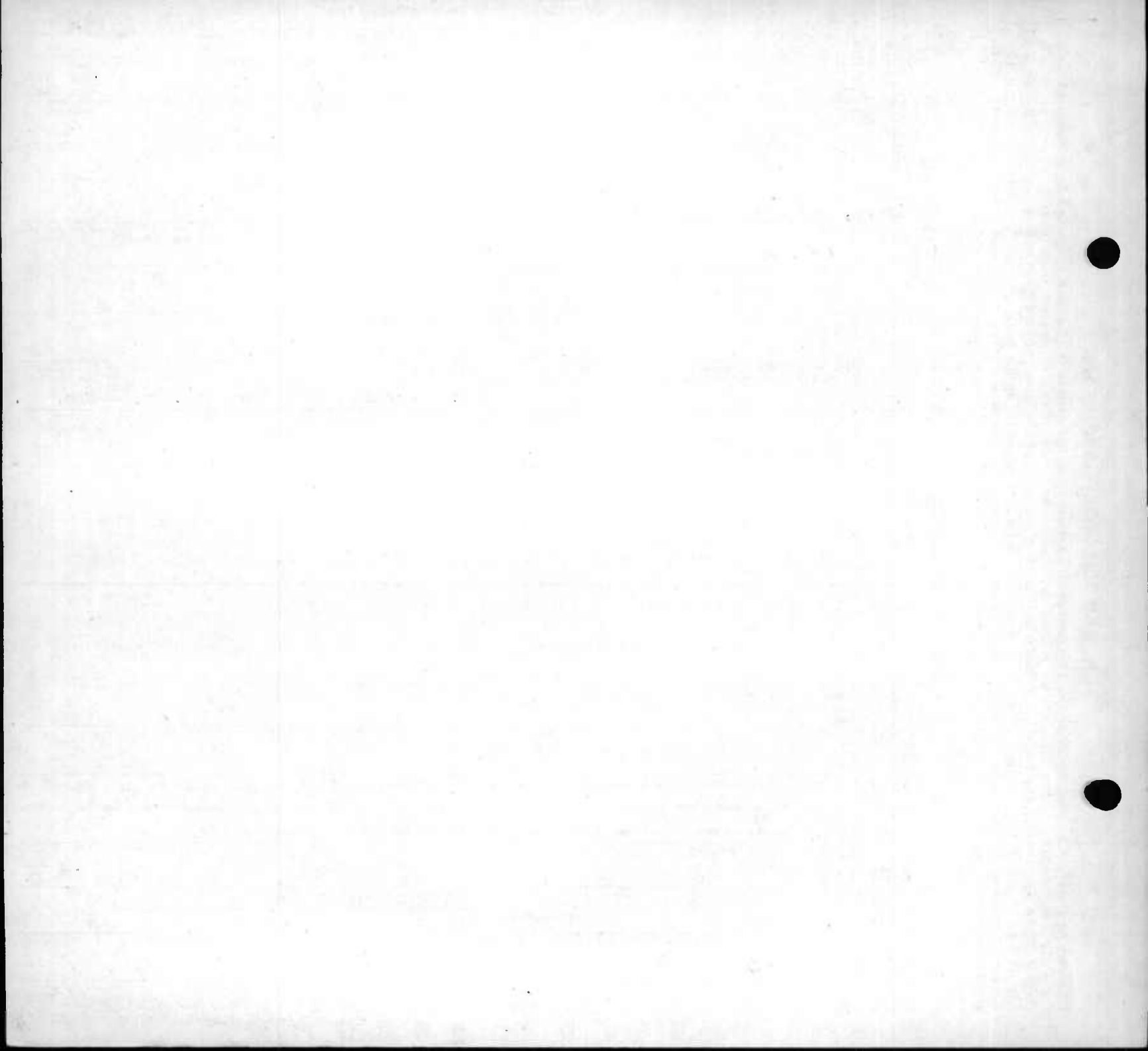
Home

ADDRESS

NE Elizabeth City

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2089

BIRTH NO. 67 2089

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HARRY BAUM

2. DATE AND HOUR PRONOUNCED DEAD

2-28-67

1:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CHURCH HOME AND HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

106 N. Luzerne Avenue 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 10, 1886

9. AGE (In years
last birthday)

81

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Photo Engraver

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Frederick S. Baum

14. MOTHER'S MAIDEN NAME

Mary Tevenian

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

213 09 5819

17. INFORMANT

106 North Linwood Avenue
Mrs Kathryn Baum

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) ~~90XXX~~

Hypertensive and arteriosclerotic

cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-1-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/4/67

23C. NAME OF CEMETERY or CREMATORY

Parkwood Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 2 1967

R. S. Fisher

HENRY SANDER & SONS INC.

BALTIMORE MARYLAND 21213

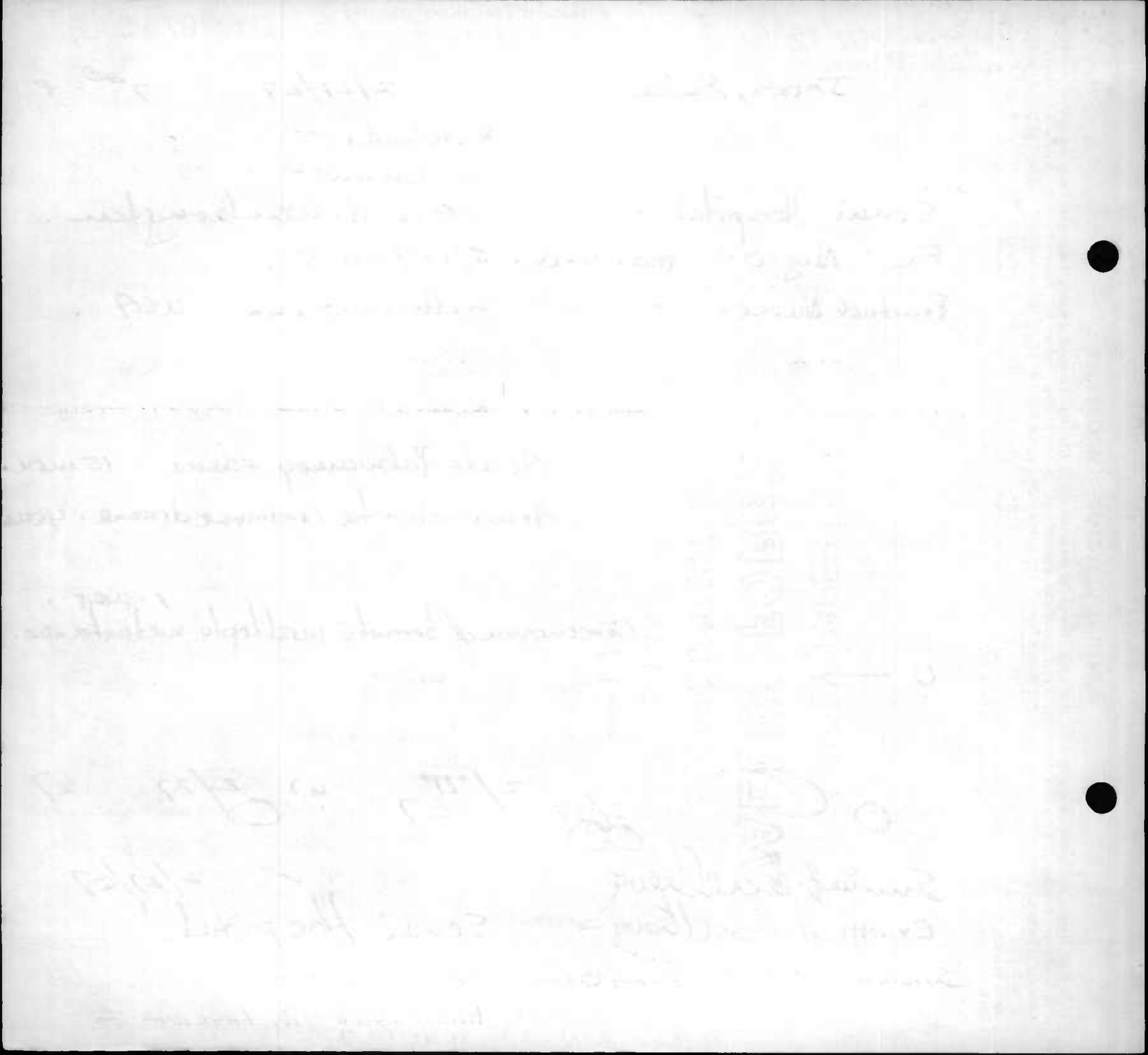
WALTER FORGE

WALTER FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

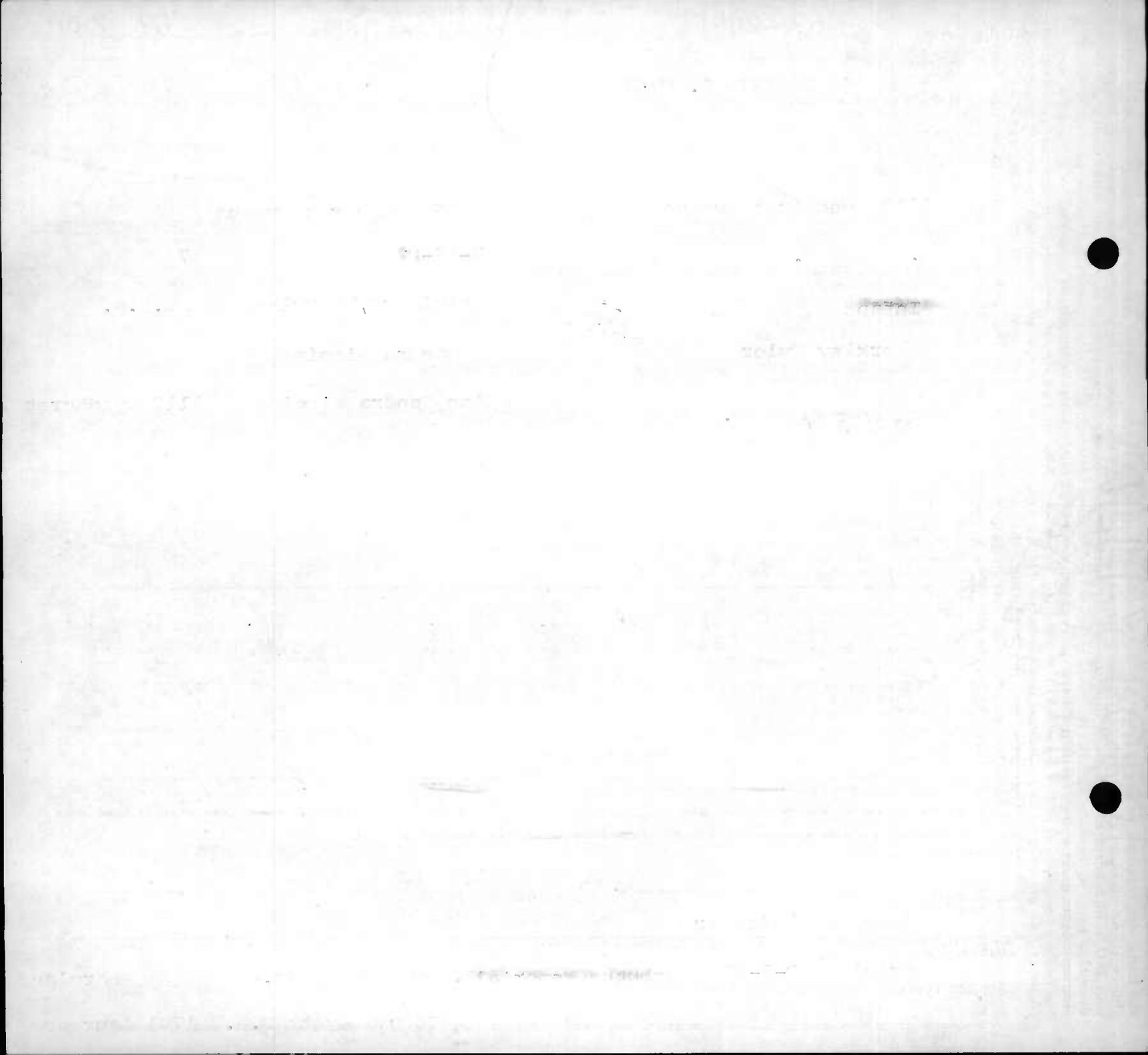
| BIRTH NO. 67 2090 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2090 | |
|---|--|--|--|--|--|------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Jones, Eula. | | | |
| 2. DATE AND HOUR OF DEATH 2/27/67 7:00 P.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital | | | | A. STATE Maryland, B. COUNTY Baltimore | | | |
| 5. SEX Female | | | | 6. RACE Negro | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | | | 8. DATE OF BIRTH 5/13/1913 | | | |
| 9. AGE (In years last birthday) 53 | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse | | | |
| 11. BIRTHPLACE (State or foreign country) South-Carolina | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME UNK. | | | | 14. MOTHER'S MAIDEN NAME UNK. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | | | 16. SOCIAL SECURITY NO. 220-14-4701 | | | |
| 17. INFORMANT Mr. James A. Jones | | | | ADDRESS 2042 N. Washington | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH (A) DUE TO Acute Pulmonary edema - 15 min. | | | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | | (B) DUE TO Arteriosclerotic Cardiovascular disease. years | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | 1 year. Carcinoma of breast - multiple metastases. | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | | 20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21A. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | | 21B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/11/67 to 2/27/67, that (I) (we) last saw the deceased alive on 2/27/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | 23A. SIGNATURE E. H. Hesselberg | | | |
| 23B. DATE SIGNED 2/27/67 | | | | 23C. PHYSICIAN'S NAME (Type) E. H. Hesselberg | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 3-4-67 | | | |
| 24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park | | | | 24D. LOCATION (City, town, or county) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | |
| 25C. FUNERAL DIRECTOR MORTON J. Dyett | | | | ADDRESS 1701 LAURENS ST. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2091 | |
|---|---------|--|------------------|---|-------------------------------|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 66-15809 2091 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| JEFFRIE L. TYLER | | 3/1/67 8:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1117 Lyndhurst Avenue | | A. STATE MARYLAND | | | |
| | | B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1117 Lyndhurst Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days |
| M. | N. | INFANT | 7-16-66 | | 7 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Infant | | | | Baltimore, Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Berkley Tyler | | Sandra Wiggins | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | Miss Sandra Wiggins 1117 Lyndhurst | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) Septicemia, Overwhelming DUE TO (B) Undetermined DUE TO (C) | | 12 hours - | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Chromosome Abnormality + Primary Apnea at Birth | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from 7/16 7/16 1966 to 3/1 1967, that (I) (we) last saw the deceased alive on 2/28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Lawrence Zollicoffer | | | | 23B. DATE SIGNED 3/1/67 | |
| 23C. PHYSICIAN'S NAME (Type) Lawrence Zollicoffer | | | | 23D. ADDRESS 3701 Marmon Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-3-67 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park | |
| | | | | 24D. LOCATION (City, town, or county) (State) Balto. Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR R. E. Johnson | | 25C. FUNERAL DIRECTOR Morton & Syrett F.H. | |
| | | | | 1701 Laurens | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

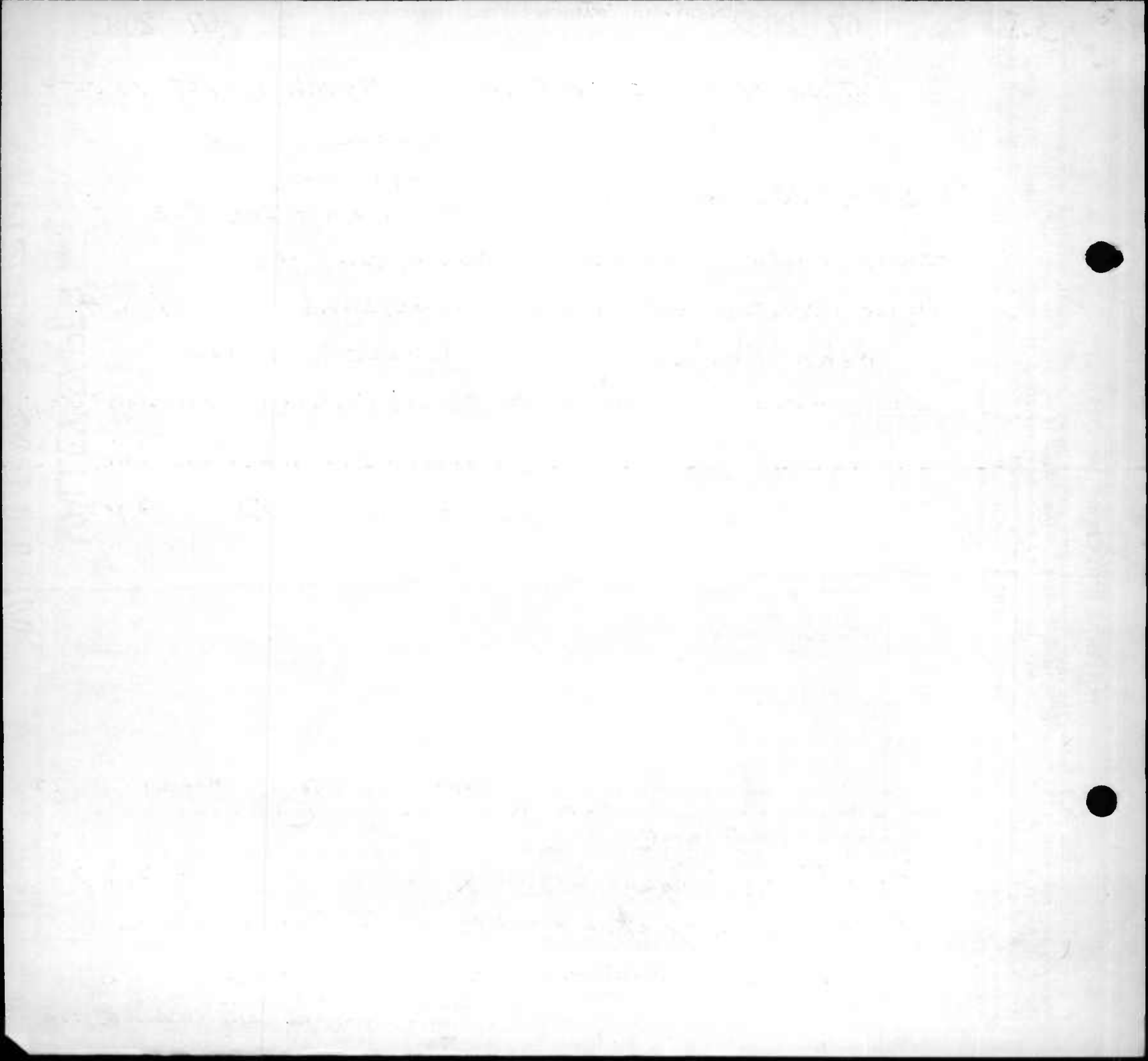
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2092</u> | |
|---|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. <u>67 2092</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Paul Bannister</u> | | 2. DATE AND HOUR OF DEATH <u>2-27-67</u> <u>3:25 P.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital, Inc.</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>2419 Callow Avenue</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>9-13-01</u> | 9. AGE (In years lost birthday) <u>65 yrs.</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia, Richmond</u> | |
| 13. FATHER'S NAME <u>PAUL BANNISTER, SR.</u> | | 14. MOTHER'S MAIDEN NAME <u>FRANCIS MCBRIDE</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>231-07-3305</u> | | 17. INFORMANT <u>Blanche Bannister</u> ADDRESS <u>2419 Callow Ave.</u> | |
| 18. <u>053.41</u> | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) <u>Cardio-respiratory Arrest</u> DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>Intra-cerebral Hemorrhage</u> DUE TO | | | |
| | | (C) <u>Septicemia</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>February 14,</u> 19 <u>67</u> to <u>February 27,</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>February 27,</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | | | 23B. DATE SIGNED <u>2-28-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS <u>Carrillo, M.D. 1514 Division Street Baltimore, Maryland</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-2-67</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Mount Auburn Cem</u> | |
| 24D. LOCATION <u>Balto., Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR <u>Morton & Dyett F.H.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>1701 Laurens</u> | | | |

11/11/12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

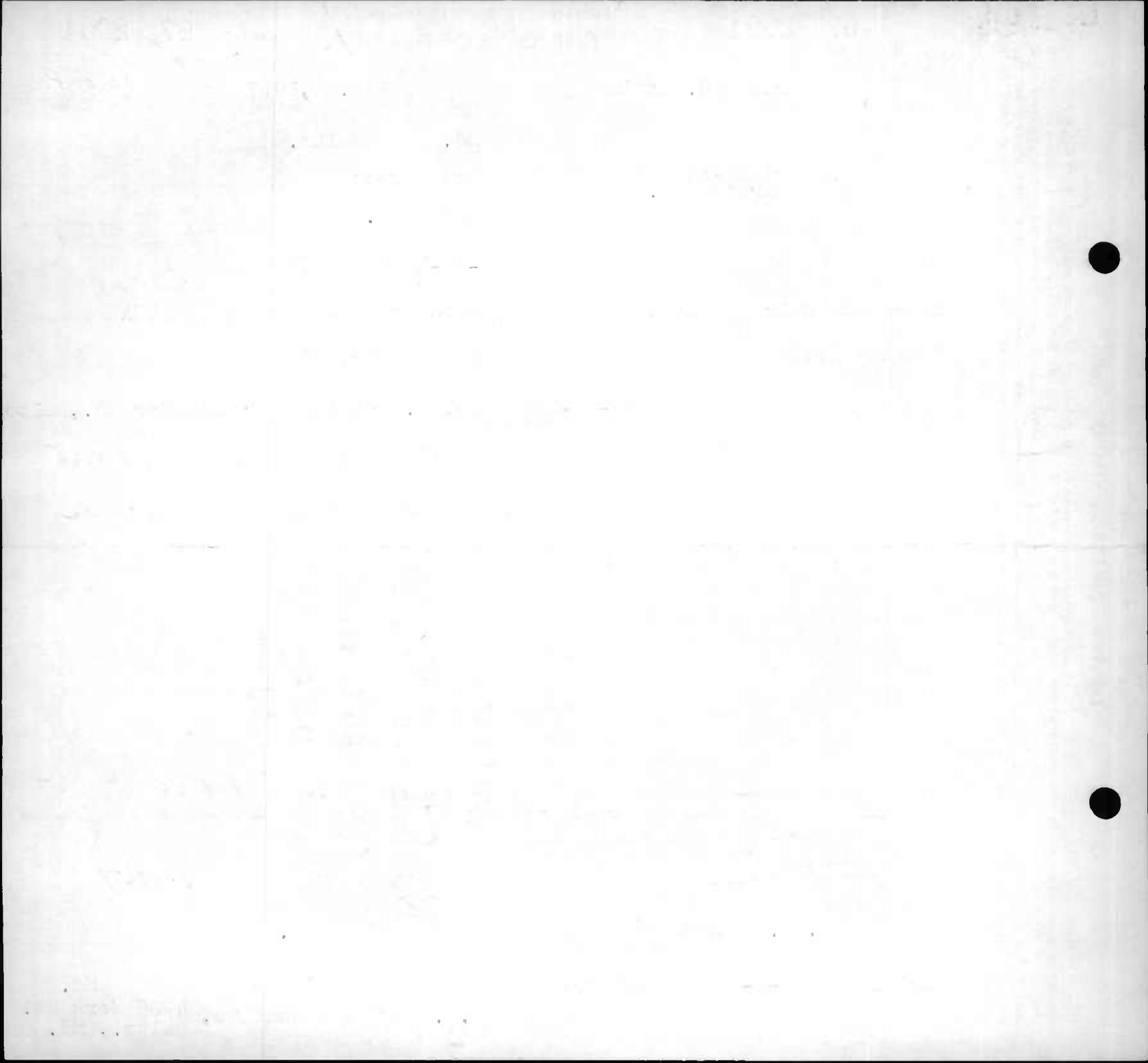
| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. 67 2093 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 67 2093 | |
| 1. NAME OF DECEASED (Type or Print) CATHERINE GRACE CURTIAN | | | 2. DATE AND HOUR OF DEATH MARCH 1, 1967 10:55 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-43 | | |
| 5. SEX FEMALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | | 8. DATE OF BIRTH NOV. 4, 1922 9. AGE (in years last birthday) 44 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | |
| 10B. KIND OF BUSINESS OR INDUSTRY ART CRAFTS | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME John Rhodes | | | 14. MOTHER'S MAIDEN NAME GRACE SULLIVAN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE | | | 16. SOCIAL SECURITY NO. 214-14-7152 | | |
| 17. INFORMANT Edward Curtian, Jr. | | | ADDRESS 2011 WHISTLER AVE. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular hemorrhage | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr. | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive CVD | | | 8 yrs. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 19 58 to March 1 19 67 , that (I) (we) last saw the deceased alive on Feb. 16 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Herbert J. Levickas | | | | 23B. DATE SIGNED 4/2/67 | |
| 23C. PHYSICIAN'S NAME (Type) Herbert J. Levickas | | | | 23D. ADDRESS M.D. 1073 Maiden Choice Lane | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-6-67 | | 24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL | |
| 24D. LOCATION (City, town, or county) BALTIMORE, MD. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fink | | 25C. FUNERAL DIRECTOR Geo. L. Schwab Funeral Home | | | |
| 25D. ADDRESS 210 Frederick Ave. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-----------|--|----------------------------|--|----------------------------------|
| BIRTH NO. 67 2094 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2094 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Ernest S. Astin | | 2. DATE AND HOUR OF DEATH Feb. 28, 1967 10:00 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Balto. Co | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) Long Green 53-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 Harford Guest Home 2926 Harford Rd. | | D. STREET ADDRESS (If rural, give location) Manor Rd. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 4-29-1887 | 9. AGE (In years last birthday) 79 | 10. CITIZEN OF WHAT COUNTRY? USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Mechanic | | 10B. KIND OF BUSINESS OR INDUSTRY Steel | | 11. BIRTHPLACE (State or foreign country) Macon Georgia | |
| 13. FATHER'S NAME Charles Astin | | 14. MOTHER'S MAIDEN NAME Mattie Sherwood | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 216-09-2199 | | 17. INFORMANT Carl R. Schmidt 3626 Elkader Rd., Balto | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Arteriosclerotic heart disease (B) Myocardial failure (C) | | INTERVAL BETWEEN ONSET AND DEATH Oct 1965 3 hours | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 10 1966 to Feb 28 1967 that (I) (we) last saw the deceased alive on Feb 28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE F. J. Alessi | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/2/67 | |
| 23C. PHYSICIAN'S NAME (Type) F. J. Alessi | | 23D. ADDRESS 6217 Harford Rd. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-3-67 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore | |
| 24D. LOCATION Baltimore | | 24E. LOCATION Baltimore | | 24F. LOCATION Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR R. E. Jenkins | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co, 4905 York Rd. Balto., Md. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2095 | |
| BIRTH NO. 67 2095 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 3-1-67 12:15 A.M. | |
| 1. NAME OF DECEASED (Type or Print) Eleanor Klee | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED Hillcrest Nursing Home 6-5-67 | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | 5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed-Married | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | 8. DATE OF BIRTH (In years last birthday) 4/4/1890 9. AGE (In years last birthday) 76 | |
| D. STREET ADDRESS (If rural, give location) 4241 Wickford Road | | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 11. BIRTHPLACE (State or foreign country) Ireland | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME James Lawrence D'Arcy | |
| 14. MOTHER'S MAIDEN NAME Mary Sullivan | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Dr. Gerald D. Klee (Same) | |
| 18. 430.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerosis, general | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | |
| 19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arthritis, rheumatoid and mild | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1960 19 March 19 67 . that (I) (we) last saw the deceased alive on Feb 28 19 67 and that in (my) (our) opinion death occurred on the date March 1 19 67 . and how and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE William G. Helfrich M.D. | | 23B. DATE SIGNED 3-1-67 | |
| 23C. PHYSICIAN'S NAME (Type) William G. Helfrich | | 23D. ADDRESS 5006 Roland Ave. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/1967 | |
| 24C. NAME OF CEMETERY or CREMATORY New Cathedral | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR H. W. Jenkins & Sons Co. | |
| 25C. FUNERAL DIRECTOR ADDRESS 4905 York Rd. Balto. 12, Md. | | | |

Death Cert. of Husband, Bertel Klee from
Phila. Pa. who died on May 25, 1967.
6-5-67 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 67 2096 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 2096 | |
| 1. NAME OF DECEASED (Type or Print) GARGIULO, Joseph Anthony | | | | 2. DATE AND HOUR OF DEATH 2-27-67 12:15 A.M. | | | |
| CERTIFICATE AMENDED | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital 3-10-67 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3806 Bayonne Ave | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 11-22-21 | 9. AGE (In years last birthday) 45 | 10. UNDER 1 Yr. Months Days | | 11. UNDER 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | | 10B. KIND OF BUSINESS OR INDUSTRY Plastics | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? United States |
| 13. FATHER'S NAME Frank GARGIULO | | | | 14. MOTHER'S MAIDEN NAME Louise | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or Unknown) (If yes, give war or dates of service) Unknown WW-2 | | | | 16. SOCIAL SECURITY NO. 211-18-958 | | 17. INFORMANT Patient Chart | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction (Massive) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cholesterol | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2/27 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (he) (this hospital) attended the deceased from 2-25 1967 to 2-27 1967 , that (he) (we) last saw the deceased alive on 2-27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John R. Vaughn, Jr. | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2-27-67 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN R. VAUGHN, JR., MD, M.D. | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/1/67 | | 24C. NAME OF CEMETERY or CREMATORY Garden of Faith | | 24D. LOCATION (City, town, or county) (State) Balto Co | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR W. Helman | | ADDRESS 6067 Hay Rd | |

General, Long the way

Union Memorial Hospital

Male White Male

Mechanic's Plaster

Frank Carcino

Unknown

Blind Baltimore

Baltimore

3806 Bayonne Ave

11-25-21 22

Maryland

Loose

Patent Chart

Patent Physiological

Patent (Baltimore)

Chilindes

Yes

John R. R. R.

5-22-67

5-22-67

5-22-67

5-22-67

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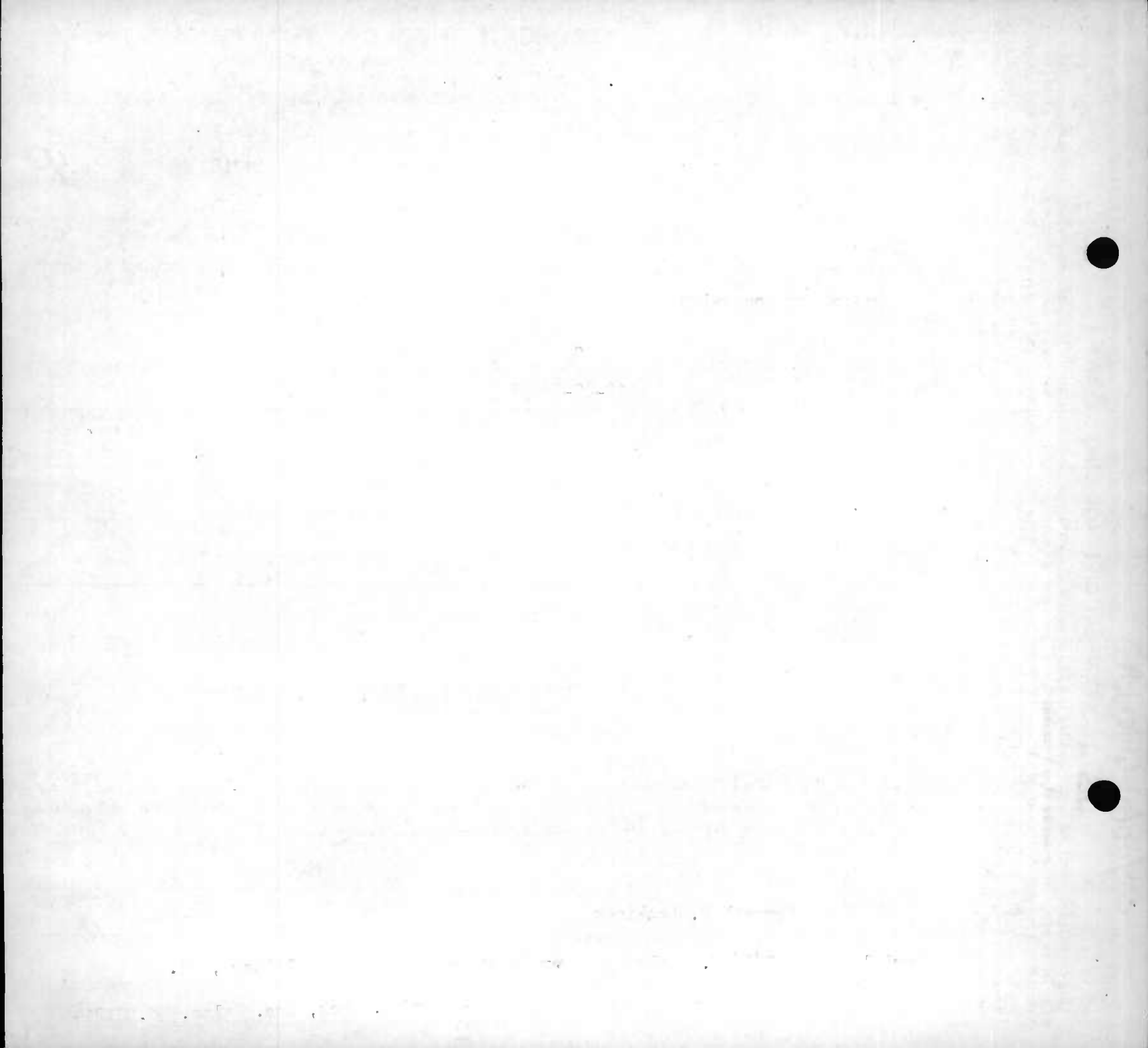
5-22-67

E. J. R. R. R.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

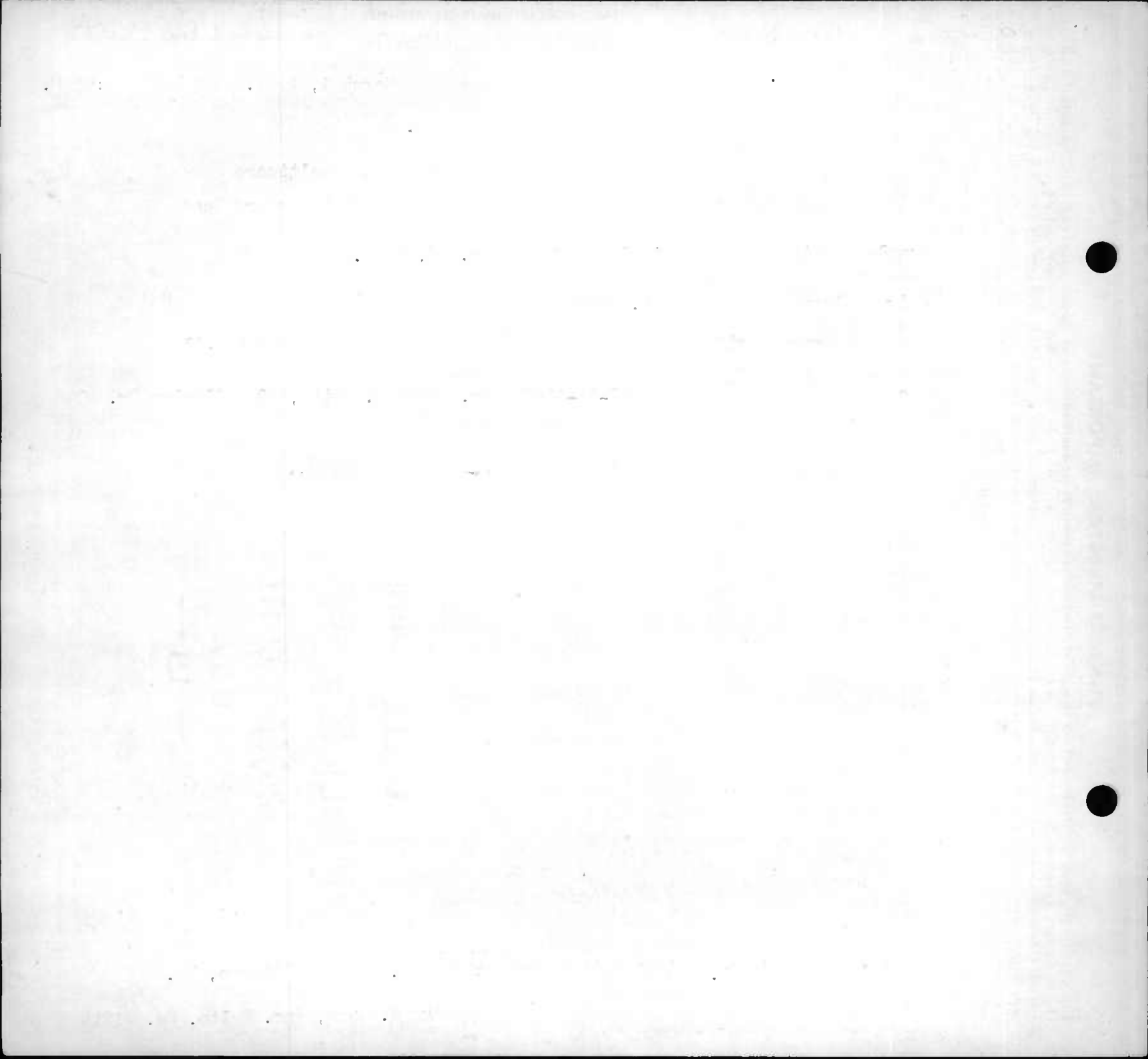
| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 67 2097 | | CERTIFICATE OF DEATH | | Registered No. 67 2097 | |
|---|---------------------|---|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print) JOSEPHINE A. MANSUETI | | | | 2. DATE AND HOUR OF DEATH 3²⁰ 3/1/67 3²⁰ A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Md GEN Hosp. BALTO., md 21201 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21218 D. STREET ADDRESS (If rural, give location) 528 E. 38th ST. | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 12-18-97 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) ITALY | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOSEPH Aicillo | | | | 14. MOTHER'S MAIDEN NAME MARY LOUISA | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 213-07-3643B | | 17. INFORMANT Kenneth R Koskinen MD | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) METASTATIC CARCINOMA FROM COLON (B) Bronchopneumonia (C) Arteriosclerotic heart disease | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2/27 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/27 19 67 to 3/1 19 67 , that (I) (we) last saw the deceased alive on 3/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Kenneth R Koskinen | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/1/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) Kenneth R. Koskinen | | | | 23D. ADDRESS Md Gen Hosp Balto., md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/3/67. | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

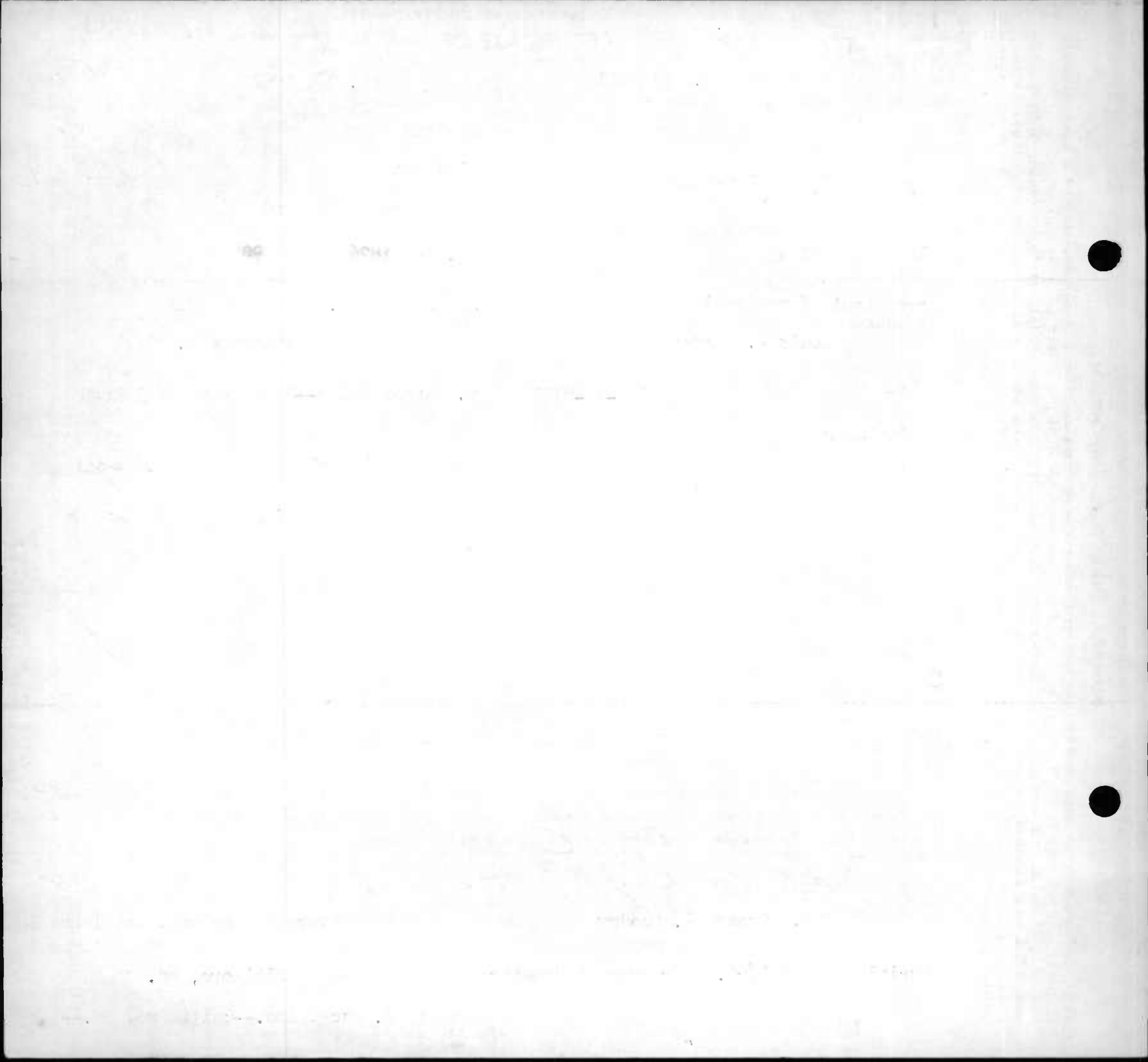
| BIRTH NO. 67 2098 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2098 | |
|---|-------------------------|---|---|---|----------------------------|--|-----------------------------|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>M. Fritz</i> | | | | March 1, 1967. 5:05 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>House of the Pines - Bel Air</i> <i>05837 Bel Air Road</i> <i>01006</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>6903 Harford Road</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>Nov. 26, 1886.</i> | 9. AGE (In years last birthday) <i>80</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Clerk</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Dept. Store</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Conrad Fritz</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Sussanna Heil</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>212-01-1162A</i> | | 17. INFORMANT ADDRESS <i>Mr. Henry C. Fritz, 2739 Kildaire Dr. #34</i> | | | |
| 18. <i>1533 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Adenocarcinoma, sigmoid Colon</i> <i>Recurrent</i> | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>9 months</i> | |
| <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | | | | | |
| 19A. DATE OF OPERATION <i>06/15/66</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma sigmoid</i> | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>August 16</i> 19 <i>49</i> to <i>February 28</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>February 28</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (We) (did not) view the body after death. | | | | | | | |
| 26A. SIGNATURE <i>Kevin F. Polak, M.D.</i> | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>3/1/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>KEVIN F. POLAK</i> | | | | 23D. ADDRESS <i>3603 Belair Road, Balto, Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3/4/67.</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>First United Evangelical Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 2 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i> | | ADDRESS <i>Balto. Md. 21214</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2099 | |
|--|-------------------------|--|---|---|--|
| BIRTH NO. 67 2099 | | M.E. CASE NO. 67 2099 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) GEORGE E. BARTELL | | | 2. DATE AND HOUR OF DEATH Feb. 28, 1967 9 15 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3959 Cloverhill Road | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3959 Cloverhill Road | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH Mar. 26, 1876 | 9. AGE (In years last birthday) 90 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant (retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Louis E. Bartell | | |
| 14. MOTHER'S MAIDEN NAME Katharine V. Plack | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 220-44-0188 | | | 17. INFORMANT ADDRESS Mr. Vernon Nolte--1302 Round Hill Road | | |
| 18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive ASCVD II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | |
| 19. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (1) (this hospital) attended the deceased from 2-26 19 67 to 2-28 19 67 , that (2) (we) last saw the deceased alive on 2-26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (3) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE RK Gundry | | | 23B. DATE SIGNED 3-1-67 | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Richard K. Gundry | | | 23D. ADDRESS 2 W. University Parkway, Baltimore 18 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/3/67. | 24C. NAME OF CEMETERY or CREMATORY Greenmount Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR Dr. E. J. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc.--Baltimore, Md.--14 | |



42-49-69 IB

D-520 67 2100

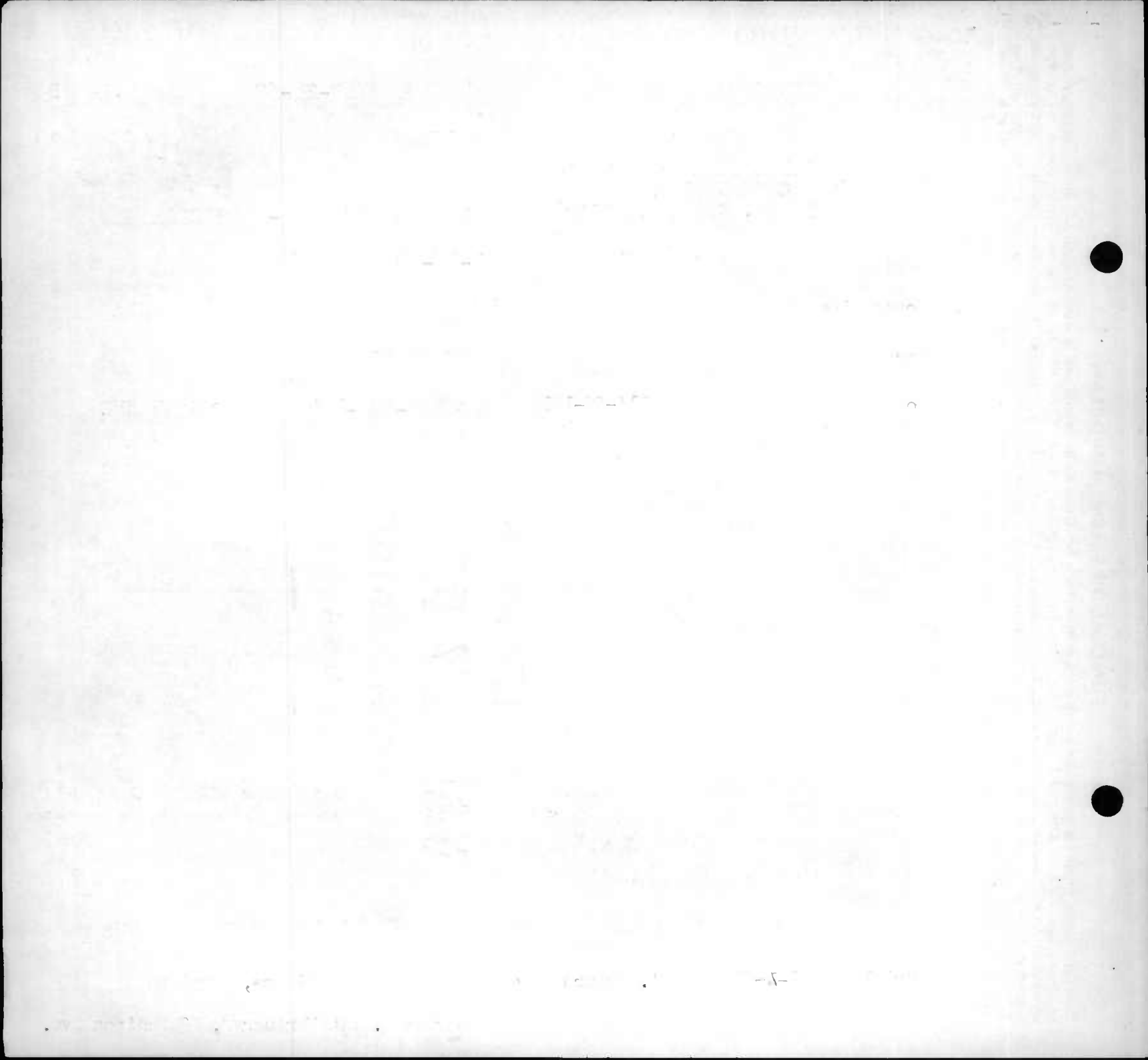
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|---|--|--|--|
| BIRTH NO. 67 2100 | | BALTIMORE CITY HEALTH DEPARTMENT | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) MATTIE JONES | | 2-28-67 9:10 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | A. STATE MARYLAND B. COUNTY Balto Co. | |
| 5. SEX FEMALE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) COUNTY 53-00 | |
| 6. RACE NEGRO | | D. STREET ADDRESS (If rural, give location) 117 OAK AVENUE - #21222 | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | E. AGE (In years last birthday) 58 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 8. DATE OF BIRTH 3-15-08 | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) 58 | |
| 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George Page | | 14. MOTHER'S MAIDEN NAME Mary Jones | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-50-1838 | |
| 17. INFORMANT #21224 | | ADDRESS RECORDS-BCH-14940 EASTERN AVENUE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolus | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. obesity | | years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/16 1967 to 2/28 1967, that (I) (we) last saw the deceased alive on 2/28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Bruce M. Dow | | 23B. DATE SIGNED 2/28/67 | |
| 23C. PHYSICIAN'S NAME (Type) BRUCE M. DOW | | 23D. ADDRESS BCH 4940 EASTERN AVENUE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-2-67 | |
| 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR Charles R. Law | |
| 25C. FUNERAL DIRECTOR | | ADDRESS Mortuary, 802 Madison Ave. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------------|--|---|---|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>67 2101</u> | | | | |
| BIRTH NO. <u>67 2101</u> | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>GEORGE T. SHERIDAN</u> | | | | | 2. DATE AND HOUR OF DEATH <u>FEB. 25, 1967</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>1406 MOSHER ST.</u> <u>00</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>808 RESERVOIR STREET</u> <u>13-02</u> | | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>COLORED</u> | 7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>DIVORCED</u> | 8. DATE OF BIRTH <u>APRIL 5, 1907</u> | 9. AGE (In years last birthday) <u>59</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITER</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | |
| 13. FATHER'S NAME <u>RIDGEWAY SHERIDAN</u> | | | 14. MOTHER'S MAIDEN NAME <u>SUSTIE BOWEN</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW II</u> | | | 16. SOCIAL SECURITY NO. <u>216-03-4943</u> | | 17. INFORMANT ADDRESS <u>EDWARD SHERIDAN - 2436 LINDEN AVE.</u> | | | | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>ANTECEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH (A) <u>CORONARY THROMBOSIS</u> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8/1/65</u> 19 to <u>2/20/67</u> 19, that (I) (we) last saw the deceased alive on <u>2/20/67</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> M.D. | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>2/27/67</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>HONNIS SENNAINE</u> | | | | | 23D. ADDRESS <u>930 WINTERCILL ST. BALT MD</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3-2-67</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 2 1967</u> | | | 25B. NAME OF REGISTRAR <u>[Signature]</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>CHARLES R. LAW 802 MADISON AVE.</u> | | | | |

1
S-360

67 2102

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2102

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

John Starr

2. DATE AND HOUR PRONOUNCED DEAD

2/27/67 7:25 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 107 N. Carey St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

107 N. Carey St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Sept. 19, 1913

9. AGE (In years
last birthday)

54 38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tree Trimmer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

William Starr

14. MOTHER'S MAIDEN NAME

Sally Goodman

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Jeffries Funeral Home Center Hall, Penna.

18. 002.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Pulmonary tuberculosis
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2/28/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-3-67

23C. NAME OF CEMETERY or CREMATORY

Zion Cemetery

23D. LOCATION

(City, town, or county)

Ceneter County

(State)

Pennsylvania

24A. DATE REC'D BY HEALTH DEPT.

MAR 2 1967

24B. NAME OF REGISTRAR

R. E. Farley

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks Inc. 1217 St. Paul Street

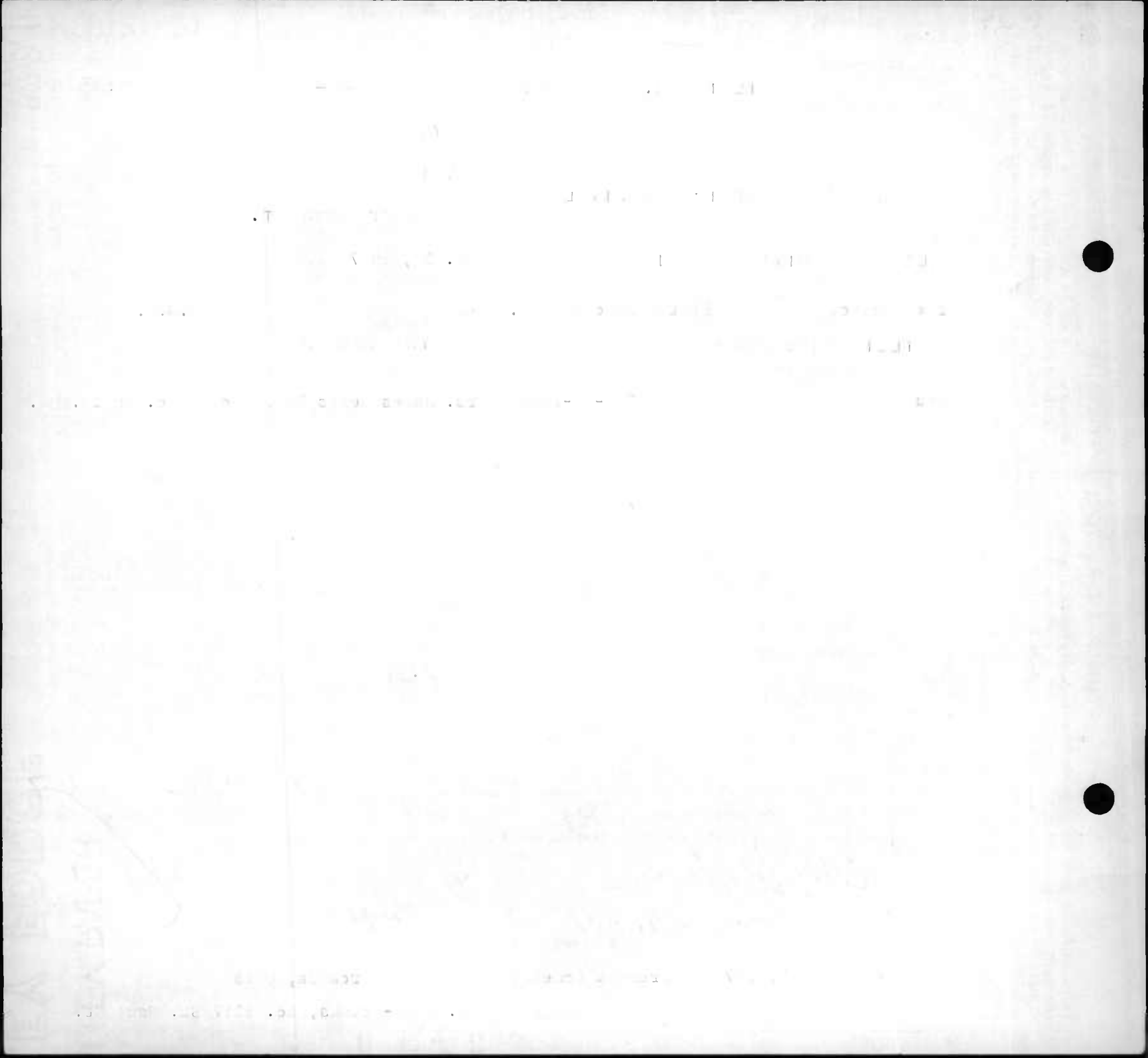
ADDRESS

19670002109

WALTER GORDON
JAMES GORDON
JAMES GORDON

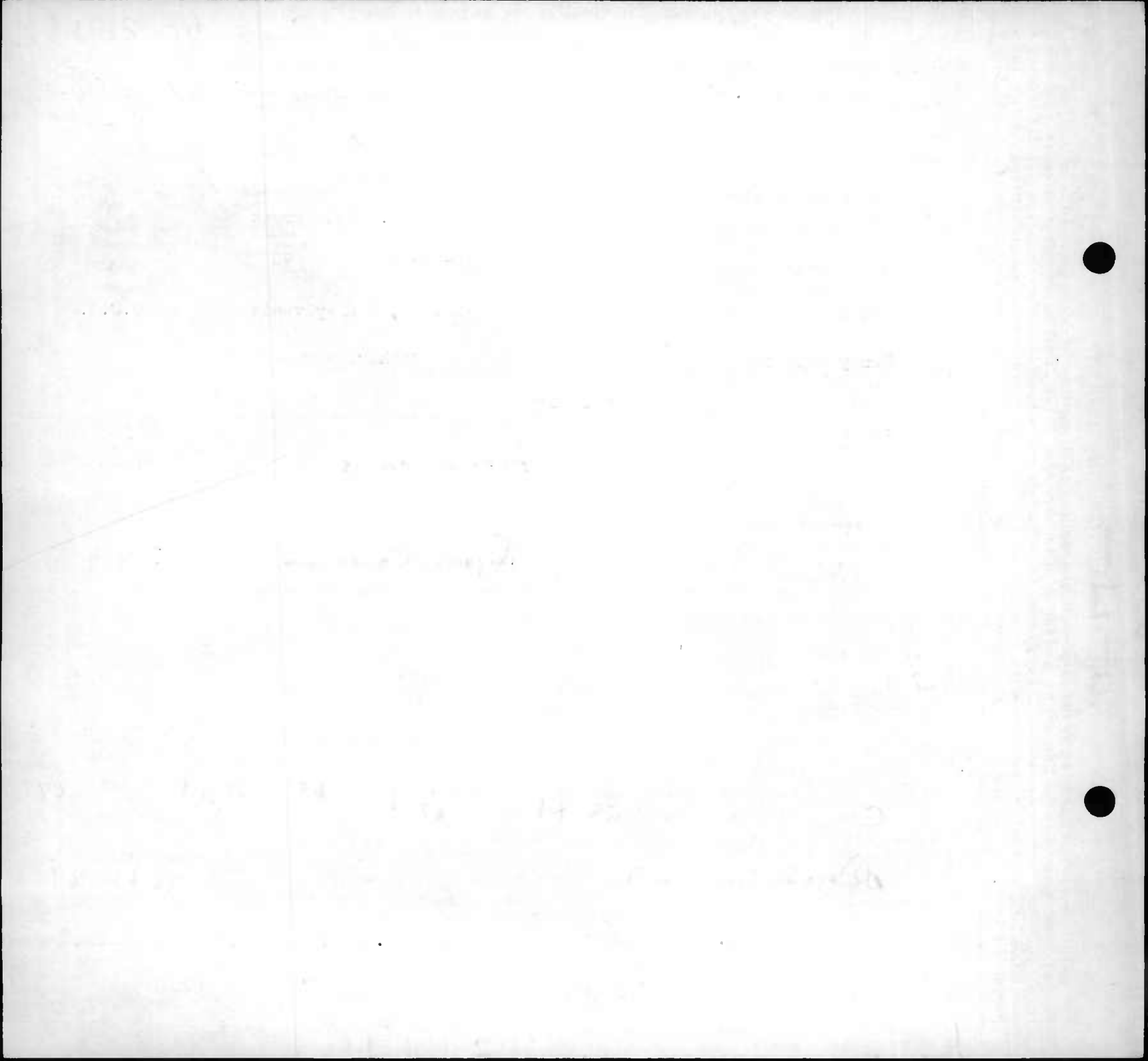
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2103 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2103 | |
|---|-------------------------|--|--|---|---|
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) WILLIAM R. ANDERSON | | | 3-2-67 1:25 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL | | | A. STATE MARYLAND B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 2227 JEFFERSON ST. | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH Nov. 20, 1967 | 9. AGE (In years last birthday) 66 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10B. KIND OF BUSINESS OR INDUSTRY Elkton Trucking Co. | | 11. BIRTHPLACE (State or foreign country) Ohio | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME WILLIE ANDERSON | | | |
| 14. MOTHER'S MAIDEN NAME MARTHA JORDAN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes | | | |
| 16. SOCIAL SECURITY NO. 218-05-7896 | | 17. INFORMANT ADDRESS Mrs. James Burns 3017 Abell Ave. Balto. Md. | | | |
| 18. 199.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) metastatic Cancer Unknown Source. | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/10 1967 to 3/2 1967 , that (I) (we) last saw the deceased alive on 3/2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W S Wilson | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/2/67 |
| 23C. PHYSICIAN'S NAME (Type) W Stan Wilson | | | 23D. ADDRESS JHH. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/5/67 | | 24C. NAME OF CEMETERY or CREMATORY Arcadia Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Arcadia, Ohio | | 25A. DATE RECEIVED BY HEALTH DEPT. MAR 2 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fairley | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks, Inc. 1217 St. Paul St. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

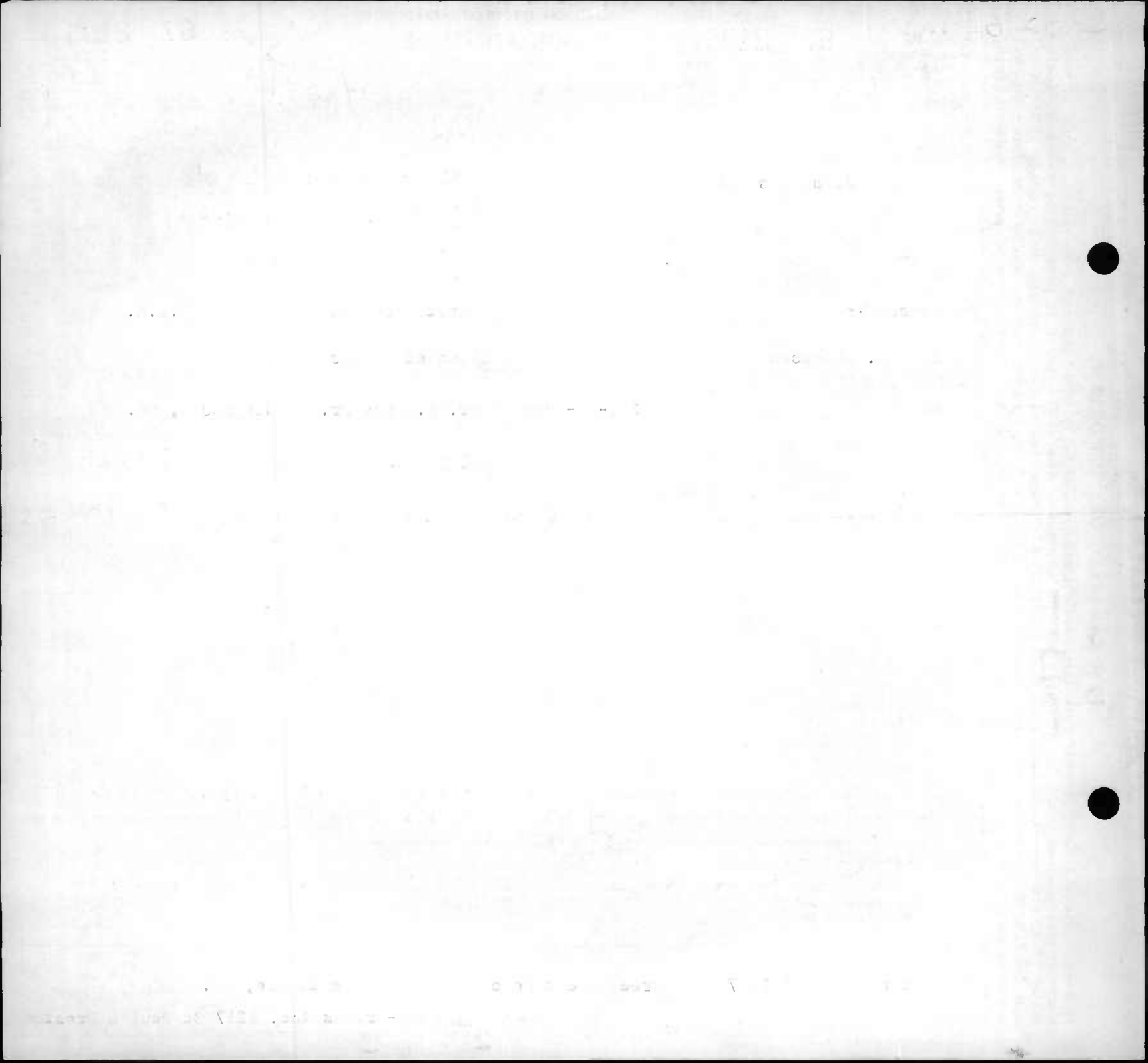
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2104</u> | |
|--|-------------------------|--|-------------------------------------|---|--|
| BIRTH NO. <u>67 2104</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Henrietta Z. Shope</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>February 28-1967</u> <u>5:25</u> <u>PM</u> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Keswick Nursing Home</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>700 W. 40th Street</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>10-21-76</u> | 9. AGE (In years last birthday) <u>90</u> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> |
| 11. BIRTHPLACE (State or foreign country) <u>Dalton, Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Henry Zeiders</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Catherine Minsker</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>126-18-8300</u> | |
| 17. INFORMANT <u>Henry Zeiders</u> | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Arteriosclerosis</u> | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Thyroid Carcinoma</u> | | (B) DUE TO | | (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>25 July 1963</u> to <u>28 Feb 1967</u> , that (I) (we) last saw the deceased alive on <u>28 Feb 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Aubrey D. Richardson M.D.</u> | | 23B. DATE SIGNED <u>28 Feb 1967</u> | | 23C. PHYSICIAN'S NAME (Type) <u>Aubrey D. Richardson</u> | |
| 23D. ADDRESS <u>700 W. 40th Street</u> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u> | | | |
| 24B. DATE <u>2/28/67</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore City, Md.</u> | |
| 25A. DATE RECEIVED BY HEALTH DEPT. <u>MAR 2 1967</u> | | 25B. NAME OF REGISTRAR <u>Wm Cook</u> | | 25C. FUNERAL DIRECTOR <u>Brookes Inc 1217 St Paul St</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

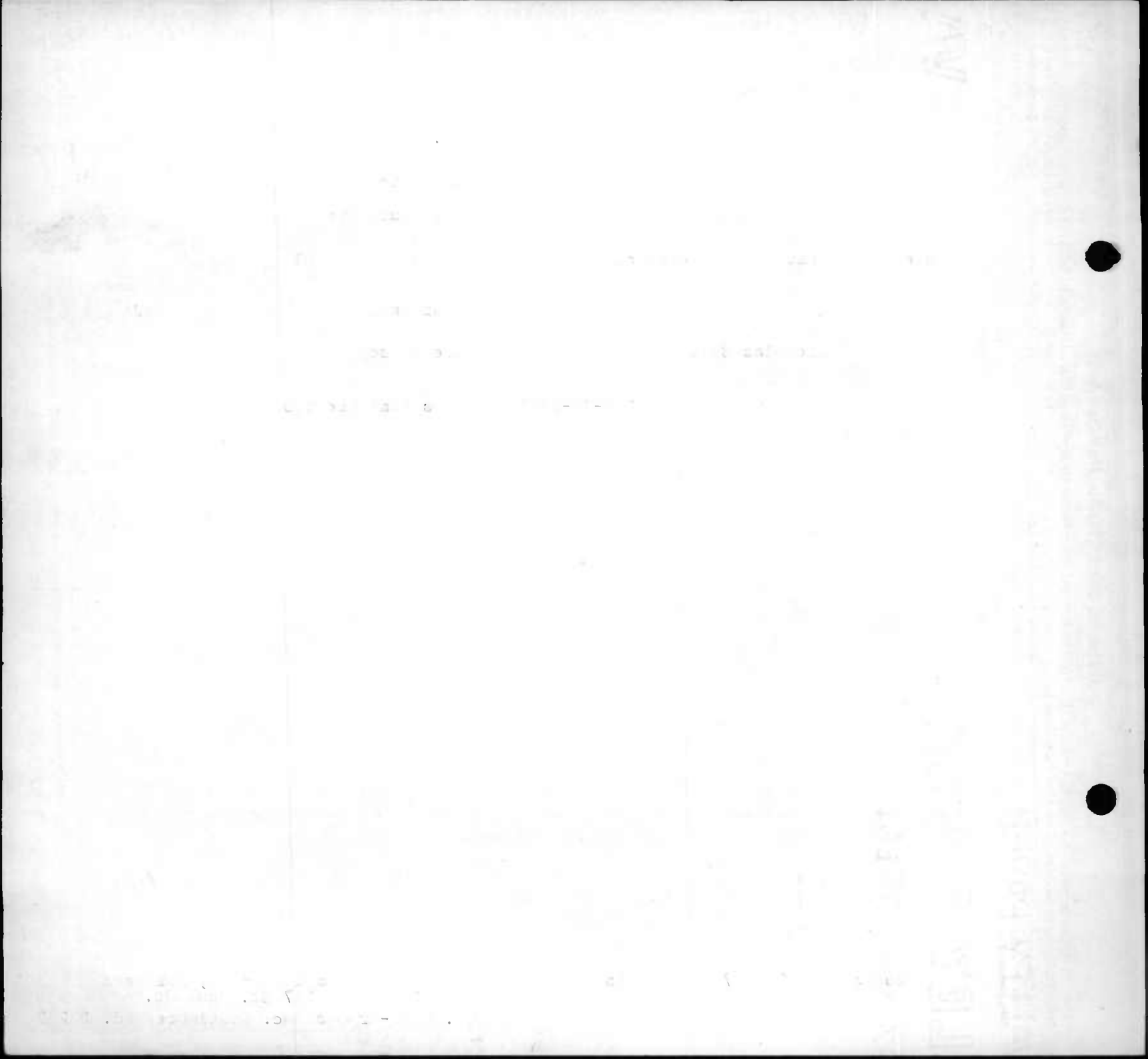
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. 67 2105 | |
|---|--------------|--|--|--|---------------------------------------|--|--|
| BIRTH NO. 67 2105 | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) LUTZ BLANCHE | | | | 2/27/67 7:55 PM. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital | | | | A. STATE Md B. COUNTY Balt Co | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) STEVENSON 53-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) PARK HTS AVE | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 1/13/82 | 9. AGE (In years lost birthday) 84 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore City | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John A. Thompson | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Wilds | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-56-4989 | | 17. INFORMANT ADDRESS Mr. R. Lutz Jr. Stevenson, Md. | | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) ASCVD DUE TO (B) Middle Cerebral Artery DUE TO Thrombosis (left) (C) | | INTERVAL BETWEEN ONSET AND DEATH ? Yrs. ? Hours | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10:AM 2/27 1967 to 2/27 7:50 PM 1967, that (I) (we) last saw the deceased alive on 2/27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE S. Gordon | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/27 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/2/67 | | 24C. NAME of CEMETERY or CREMATORY Green Mount Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | 25B. NAME OF REGISTRAR R. E. Taylor | | 25C. FUNERAL DIRECTOR Wm Cook-Brooks Inc. 1217 St Paul & Preston | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2106 | |
|---|-----------------------|--|---|--|--|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 2106 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) William Smith | | | 2. DATE AND HOUR OF DEATH 2-28-67 8¹⁵ P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 14-01 D. STREET ADDRESS (If rural, give location) 1616 Park Ave | | |
| 5. SEX Male | 6. RACE Cau | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 9/19/83 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Nicholas Smith | | | 14. MOTHER'S MAIDEN NAME Sue Rousey | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-32-5993 | 17. INFORMANT ADDRESS Hospital Records | | |
| 18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aspiration pneumonia 3 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ② cerebro vascular thrombosis 7 days ASVD | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2/25/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture of femur | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from Feb 25 1967 to Feb 28 1967 , that (1) (we) last saw the deceased alive on Feb 28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard D. Shuger M.D. | | | | 23B. DATE SIGNED 3/1/67 | |
| 23C. PHYSICIAN'S NAME (Type) RICHARD D. SHUGER M.D. | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/4/67 | | 24C. NAME OF CEMETERY or CREMATORY Woodlawn | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 2 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS 1217 St. Paul St. Wm. Cook-Brooks Inc. Baltimore, Md. 21202 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2107 | |
|--|---------|--|---|--|------------------------------|
| BIRTH NO. 67 2107 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | DAISY | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | DAISEY R. PALMER | | 3/1/67 5 ⁵⁰ A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | Md | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| 1121 N. Calvert St | | Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) | | 1121 N. Calvert St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| Female | White | Widowed | 10/12/80 | 86 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Landlady | | Self Employed | Georgia | | USA |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| ? Ringer | | | Julie Langford | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| No | | 219-32-2358 | Mrs Julia Mayes 1119 N. Calvert St. Balt. Md. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | Arteriosclerotic Vascular Disease 2 yrs | |
| ANTECEDENT CAUSES | | (B) DUE TO | | Circulatory Failure 2 months | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | Diabetes Mellitus several yrs | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 1954 to Mar 1 1967, that (I) (we) last saw the deceased alive on 2/26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Samuel Morrison | | | | 3/1/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| SAMUEL MORRISON | | 11 E. Chase St Balto. Md 21202 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3/3/67 | | Moreland | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. FUNERAL DIRECTOR ADDRESS | | | |
| Baltimore Co. Maryland | | 1217 St. Paul St. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| | | | | Wm Cook-Brooks Inc. Baltimore, Md. 21202 | |

V.S. 153

3-7-67

M.H.

1
W-432

67 2108

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2108

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

COLOMBUS

WILTZ

2. DATE AND HOUR PRONOUNCED DEAD

February 26, 1967

6:20 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 528 Richwood Avenue

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

528 Richwood Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

3-15-1903

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Rigger

10B. KIND OF BUSINESS OR INDUSTRY

Metal Co.

11. BIRTHPLACE (State or foreign country)

Kilmonic, Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edmond Wiltz

14. MOTHER'S MAIDEN NAME

Eva Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

317-05-4074 Thelma Wiltz 528 Richwood Ave.

17. INFORMANT

ADDRESS

18.

153.8

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cachexia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Carcinoma of Colon (by history)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2/27/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-2-67

23C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

Anne Arundel Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 2 1967

24B. NAME OF REGISTRAR

Robert E. Farkner

24C. FUNERAL DIRECTOR

Randolph J. Collick 2431 E. Oliver St.

ADDRESS

MAILED BY PCNAB

NOV 19 1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 67 2109 | |
|--|-------------------------|---|---|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 2109 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <u>William Forest Foster</u> | | | 2. DATE AND HOUR OF DEATH <u>FEB 28, 1967</u> <u>8 55</u> A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Ky</u> B. COUNTY <u>GRAVES</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>37 Mercy Hospital</u> <u>BALTIMORE, MD</u> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>RURAL - MAYFIELD V-15</u> | | |
| D. STREET ADDRESS (If rural, give location) <u>RFD #6 - FOSTER LAKE</u> | | | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>AUG 1, 1896</u> | 9. AGE (In years last birthday) <u>70</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESIDENT/GENERAL MANAGER - MERIT CLOTHING CO.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>CHARLES S. FOSTER</u> | | 14. MOTHER'S MAIDEN NAME <u>ELLEN BENNETT</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Dr. Greg Bruce Mercy Hospital</u> | |
| 18. <u>153.3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HEMORRHAGE, RIGHT CEREBRUM, TEMPORAL OCCIPITAL LOBE, BASAL ASPECT; ASCVD</u> <u>PSEUDOMONAS BACTEREMIA, PERITONITIS; & PERIPALVIC SAT ABSCESS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ADENOCARCINOMA SIGMOID COLON & EROSION INTO BLADDER, METASTASIS TO (R) LIVER DOME</u> <u>BILATERAL PULMONARY ATELECTASIS, ASPIRATION PNEUMONITIS, STRESS ULCERS-STOMACH</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>36 hr</u> <u>3-4 wks</u> <u>6 MONTHS</u> <u>1 wk</u> <u>24 hrs</u> | | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION <u>JAN. 17, 1967</u> <u>FEB. 23, 1967</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ADENOCARCINOMA SIGMOID COLON</u> | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>YES</u> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>JAN. 17, 1967</u> to <u>FEB. 28, 1967</u> , that (I) (we) lost saw the deceased alive on <u>FEB. 28, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Wm Gregory Bruce</u> M.D. | | | | 23B. DATE SIGNED <u>FEB 28, 1967</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Wm Gregory Bruce</u> | | | | 23D. ADDRESS | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 24B. DATE <u>2/28/1967</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mayfield, Kentucky</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Mayfield, Kentucky</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 3 1967</u> | | 25B. NAME OF REGISTRAR <u>R. G. E. Taylor</u> | |
| 25C. FUNERAL DIRECTOR <u>Wm J. Johnson</u> | | 25D. ADDRESS <u>Balti, Md.</u> | | 25E. ADDRESS <u>North 2nd St.</u> | |

1912 - 1913
1914 - 1915

1916 - 1917
1918 - 1919

1920 - 1921
1922 - 1923

1924 - 1925
1926 - 1927

1928 - 1929
1930 - 1931
1932 - 1933
1934 - 1935

1936 - 1937
1938 - 1939
1940 - 1941
1942 - 1943

1944 - 1945
1946 - 1947

1948 - 1949
1950 - 1951

1952 - 1953
1954 - 1955

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|------------------------------------|---|--|
| BIRTH NO. 67 2110 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2110 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| WORTHINGTON, RICHARD WALKER | | 2-26-67 | | 5:30 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL CATON & WILKENS AVE. BALTIMORE, MD. 21229 | | A. STATE MARYLAND B. COUNTY 21218 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 12-01 40 W. 39TH ST. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 5-13-79 | 9. AGE (In years last birthday) 87 | 10. Under 1 Tr. Months: Days: Hours: Min. 87 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - executive | | 10B. KIND OF BUSINESS OR INDUSTRY FIDELTY & DEPOSITE CO. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME THOMAS C. WORTHINGTON | | 14. MOTHER'S MAIDEN NAME Katherine WALKER | |
| 15. Was Deceased in U. S. Armed Forces? (Yes, no or unknown. If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-14-0922 | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVE. 21229 | |
| 18. 332 X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CVA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral thrombosis | | CAUSE OF DEATH (A) CVA DUE TO (B) Cerebral thrombosis DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-24 19 67 to 2-26 19 67 , that (I) (we) lost saw the deceased alive on 2-26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Archie Hooton | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) DR. ARCHIE HOOTON | | 23D. ADDRESS ST. AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/1/1967 | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Pikesville, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1967 | | 25B. NAME OF REGISTRAR Wm. J. Fisher & Son | |
| 25C. FUNERAL DIRECTOR ADDRESS Baltimore, Md. | | | | | |

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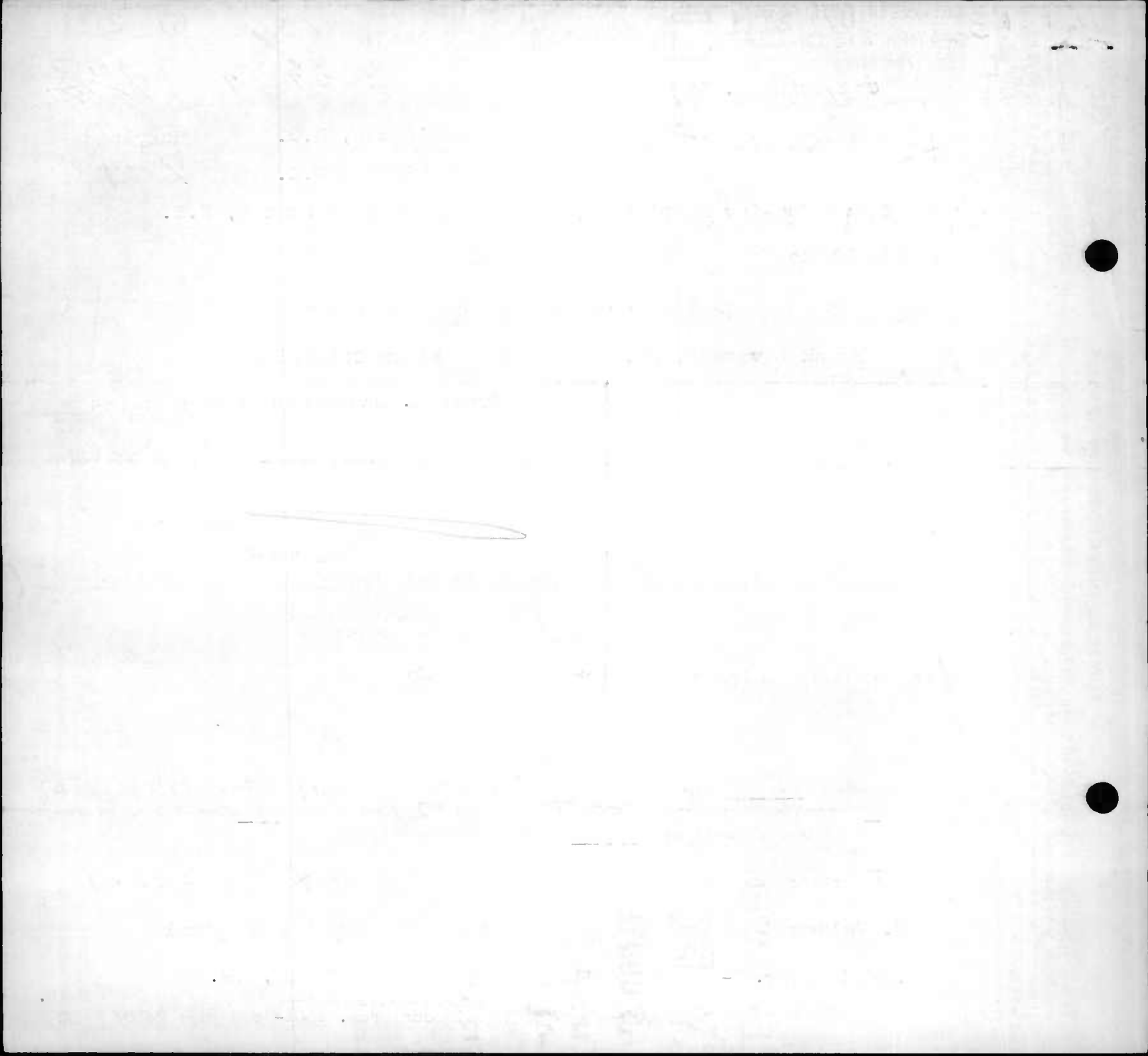
...STATION, AND ...

...STATION, AND ...

...STATION, AND ...

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED No. | |
|---|---------|--|------------------|--|---------------------------------|
| 67 2111 | | CERTIFICATE OF DEATH | | 67 2111 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Catherine M. Lavorata | | 2-27-67 7:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 | | Washington, D.C. Maryland | | | |
| The Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Washington D.C. V-48 | | | |
| | | D. STREET ADDRESS (If rural, give location) 3658 Bangor Street, S.E. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days |
| Female | White | Child | 01/08/59 | 8 | Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Student St Francis Xavier School | | | | Washington, DC | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Frank Laborata, Jr. | | Flora Calessime | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Frank L. Lavorata Jr Same as Item #4 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) CARDIO-RESPIRATORY ARREST. DUE TO (B) ? DUE TO (C) AORTIC STENOSIS INCREASED INTRACRANIAL PRESSURE AND MENINGEAL IRRITATION. | | 1:35 hours - 6 years. - 10 days. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | ARNOLD-CHIARI MALFORMATION SANA BIPHIDA AND MENINGOCELE | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| Feb 14, 1967 | | AORTIC STENOSIS | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 11th 1967 to Feb 27th 1967, that (I) (we) lost saw the deceased alive on Feb 27th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE F. Velasco. | | | | 23B. DATE SIGNED 2-27-67 | |
| 23C. PHYSICIAN'S NAME (Type) F. Velasco | | | | 23D. ADDRESS The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | Mar. 2-67 | | Cedar Hill Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAR 3 1967 | | Robert E. Taylor | | Simmons Bros. | |
| | | | | ADDRESS Wash. 1661-Good Hope Rd SE DC | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

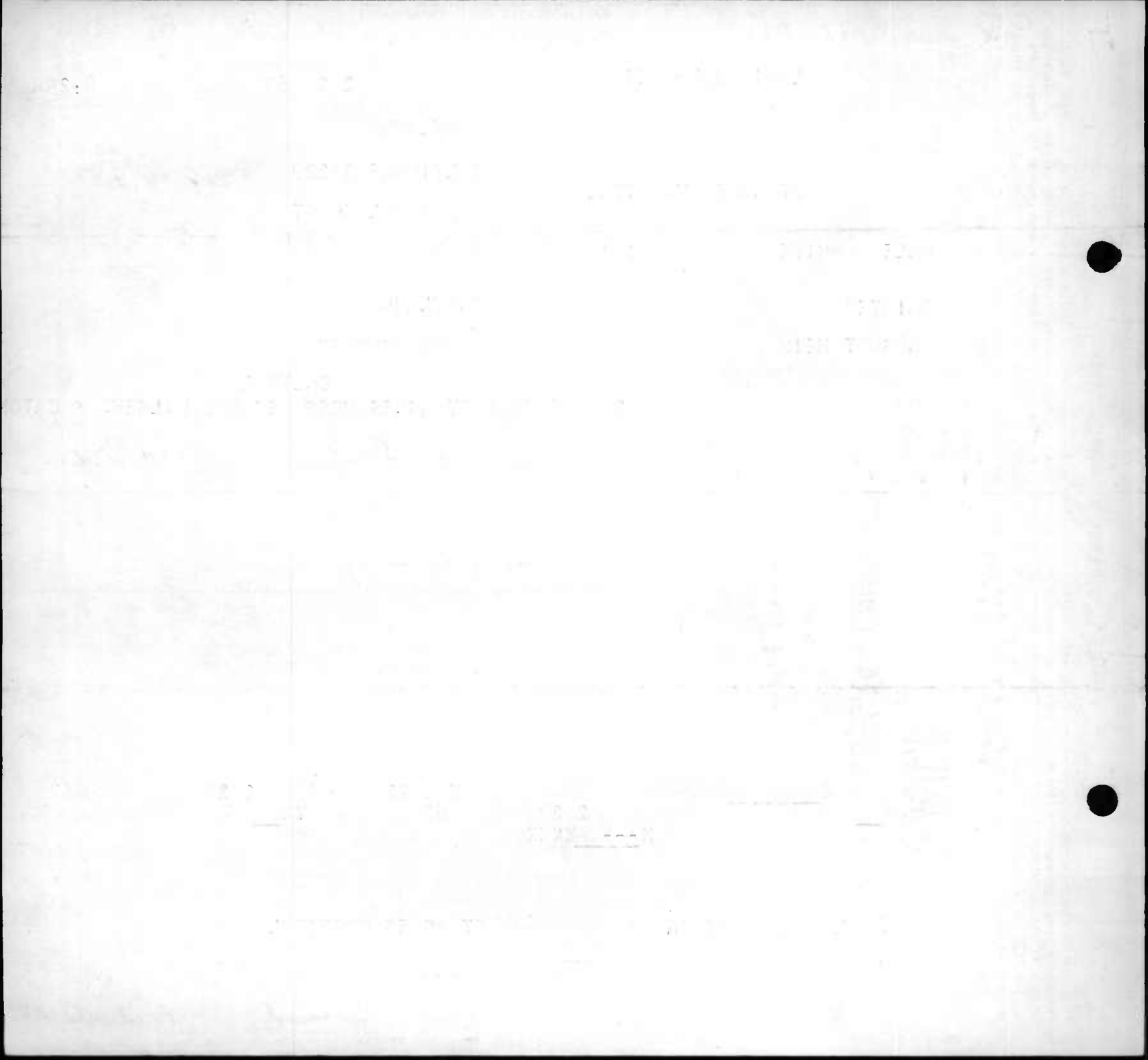
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|--|--|-------------------------|--|--|--|------------------------------------|---|---|--|--|--|--|---|--|--|--|--|--|--|
| BIRTH NO. 67 2112 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 2112 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) BLADES, Webster Strayer | | | | | | | | | | 2. DATE AND HOUR OF DEATH February 25, 1967 5:15 P.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218 | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 11-02 D. STREET ADDRESS (If rural, give location) 15 West Madison Street | | | | | | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 12/6/88 | | 9. AGE (In years last birthday) 78 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer | | | | | 10B. KIND OF BUSINESS OR INDUSTRY Law Firm | | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | |
| 13. FATHER'S NAME Jehu Blades | | | | | 14. MOTHER'S MAIDEN NAME Emma Patton | | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11-27-17 to 4-15-19 | | | | | | | | | |
| 16. SOCIAL SECURITY NO. 218-32-5876 | | | | | 17. INFORMANT Records Veterans Administration Hospital 3900 Loch Raven Blvd, Baltimore, Md. 21218 | | | | | ADDRESS | | | | | | | | | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Bronchogenic Carcinoma, Right Lung; Status Post Radiation (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Atelectasis, Fivrosis Right Lung. Pulmonary Congestion And Edema, Left Lung. | | | | | | | | | | CAUSE OF DEATH Bronchogenic Carcinoma, Right Lung; Status Post Radiation | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION 0 | | | | | | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | | | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from November 29, 1966 to February 25, 1967 , that (X) (we) last saw the deceased alive on February 25, 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Pushpendra Senan M.D. | | | | | | | | | | 23B. DATE SIGNED 2/26/67 | | | | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Pushpendra Senan M.D. | | | | | | | | | | 23D. ADDRESS Veterans Administration Hospital Baltimore, Maryland 21218 | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE Mar. 1, 1967 | | 24C. NAME OF CEMETERY or CREMATORY Union Grove Cemetery | | | | | 24D. LOCATION (City, town, or county) (State) Near Preston, Maryland | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1967 | | | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | | | 25C. FUNERAL DIRECTOR W. J. Brampton and Son, Federalburg, Md. | | | | | | | | | |

Prüfung der Bewerber

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2113 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2113 | |
|--|------------------|--|-----------------------------|--|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) LOUIS JOHN HEIM | | | | 2. DATE AND HOUR OF DEATH 2 27 67 8:25A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21229 20-07 D. STREET ADDRESS (If rural, give location) 63 S CULVER ST | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 9 14 98 | 9. AGE (In years lost birthday) 68 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER | | 10B. KIND OF BUSINESS OR INDUSTRY SELF-EMP. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME AUGUST HEIM | | | | 14. MOTHER'S MAIDEN NAME MARY SCHORCK | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 217 16 6773 | | 17. INFORMANT BALTO 29 MD | | ADDRESS BALTO 29 MD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 163X I CAUSE OF DEATH (A) Cerebral Coma (B) Brain metastasis (C) Ca of the Lung INTERVAL BETWEEN ONSET AND DEATH 1 1/2 weeks - | | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 1 22 19 67 to 2 27 1967 that (X) (we) lost saw the deceased alive on 2 27 19 67 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Alejandro Mejia M.D. | | | | 23B. DATE SIGNED 2-27-67 | | | |
| 23C. PHYSICIAN'S NAME (Type) DR ALEJANDRO MEJIA | | | | 23D. ADDRESS ST AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE March 2, 1967 | | 24C. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1967 | | 25B. NAME OF REGISTRAR R. E. Farley | | 25C. FUNERAL DIRECTOR Farley - Cavanaugh | | ADDRESS Frederick Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2114 | |
|---|--|---|--|----------------------------------|--|
| BIRTH NO. 67 2114 | | CERTIFICATE OF DEATH | | Registered No. 67 2114 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Schneider, Henry P. | | February 28, 1967 6:10 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| ST. AGNES HOSPITAL | | Md. XXXXXXXX Anne Arundel Co | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | 52-00 | |
| | | D. STREET ADDRESS (If rural, give location) | | 424 Shipley Road | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Male | White | Widowed | 5/12/85 | 81 | RETIRED |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| | | Baker Cork & Tile | MARYLAND | USA | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| UNKNOWN | | | UNKNOWN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| UNKNOWN None | | 212 05 8076 | Mr. Philip T. Schneider (Son) Same as #4 | | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) DUE TO | | Pulmonary Edema | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | Coronary Ischemia | |
| | | (C) DUE TO | | ASCVD | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Pneumonitis | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Nat. While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 2/28 4:00P 1967 to 2/28 6:10P 1967, that (X) (we) last saw the deceased alive on 2/28 6:10P 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Ewald H. Weiss | | | | 2/28/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Ewald H. Weiss | | BALTO. MD. 21229 ST. AGNES HOSPITAL-CATON & WILKENS AVES. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | Mar. 3, 1967 | Parkwood Cemetery | Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR ADDRESS | | |
| MAR 3 1967 | | Robert E. Fairbank | Eugene B. Fleming | | |
| | | Singleton Funeral Home Glen Burnie, Md | | | |

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Handwritten signature

48-71-61 1B D-670 67 2115

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

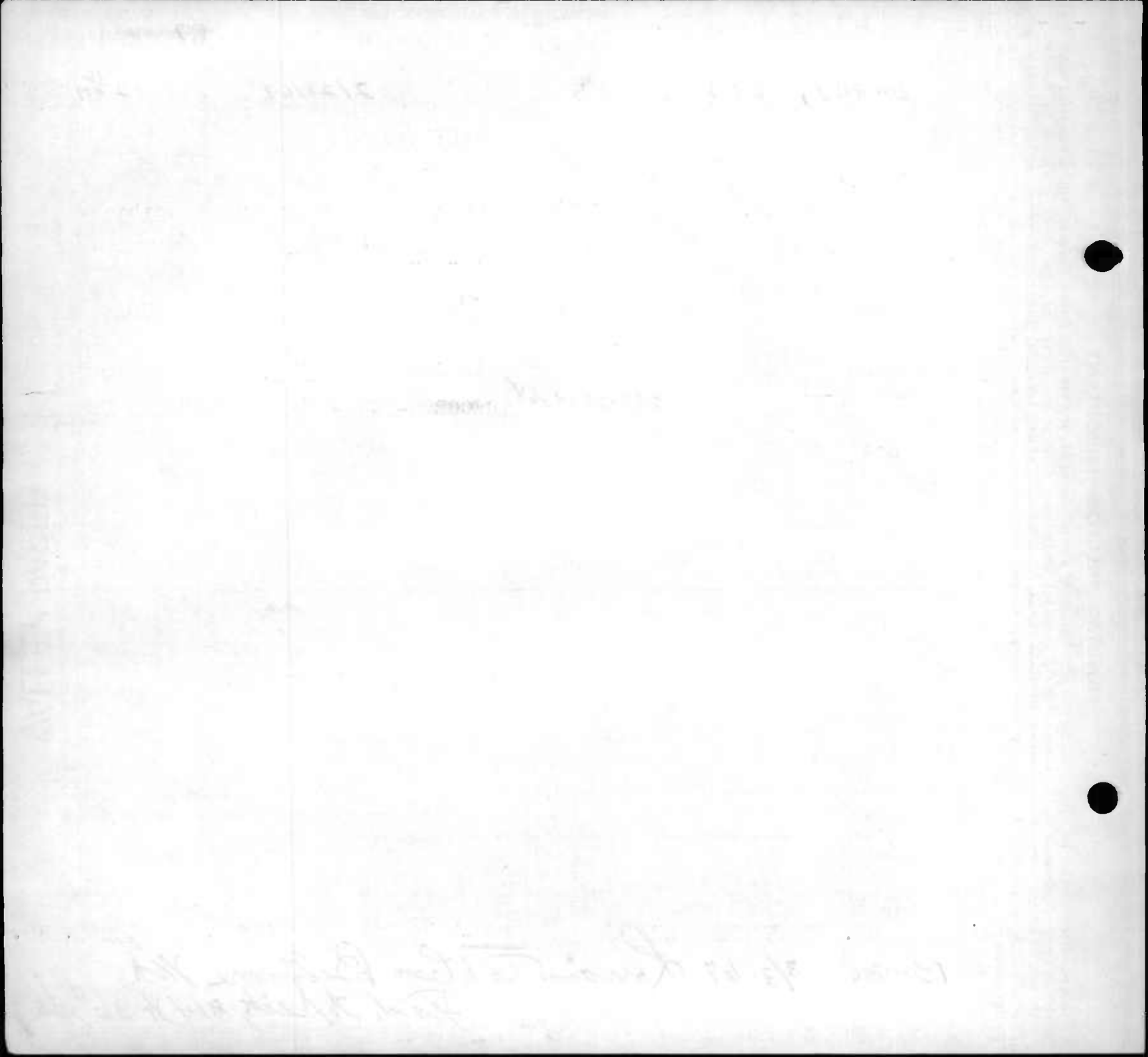
Registered No. 67 2115

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|------------------|---|---|--|---|---|--|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | DARBY, OTIS | | 2/28/67 12:45 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | | | A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4400 BUCHANAN AVENUE #21211 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 12-25-05 | 9. AGE (In years last birthday) 61 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | |
| 10B. KIND OF BUSINESS OR INDUSTRY Auto Paint Shop | | | 11. BIRTHPLACE (State or foreign country) OKLAHOMA | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME CHARLIE | | | | 14. MOTHER'S MAIDEN NAME NANCY LOTTEMILL | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 253-22-3668 | | 17. INFORMANT 21224 RECORDS-BCH -4940 EASTERN A VENUE | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARDIAC ARREST INTERVAL BETWEEN ONSET AND DEATH | | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2/1/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/1/67 19 67 to 2/28 19 67, that (I) (we) last saw the deceased alive on 2/28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Stuart Beal Silver | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/28/67 | |
| 23C. PHYSICIAN'S NAME (Type) DR. STUART BEAL SILVER | | | | 23D. ADDRESS 21224 BCH-4940 EASTERN AVENUE, BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/3-67 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cem | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robert S. Feltz | | 25C. FUNERAL DIRECTOR Frank H. Seitz 814 N 36th St | | ADDRESS | |

MAR 3 1967



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L-500

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 2116 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2116

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JOSHUA Humphrey's LANE 2. DATE AND HOUR PRONOUNCED DEAD February 24, 1967 3:05 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 99 Lutheran Hospital (DOA)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

834 William St.

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married 8. DATE OF BIRTH Feb 4, 1910 9. AGE (In years last birthday) 57 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE DEPT 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? USA

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE DEPT 10B. KIND OF BUSINESS OR INDUSTRY UPHOLSTERY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles W. LANE 14. MOTHER'S MAIDEN NAME ANNA LAUR Humphrey's

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 216-16-9291 17. INFORMANT ADDRESS Enoch W. LANE, HARWOOD, MD

18. CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic heart disease (A) DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER ACTUAL SIGNATURE Charles S. Springate, M.D. DATE SIGNED 2-25-67 EXAMINER'S NAME (Type) Charles S. Springate, M.D.

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 2- 23C. NAME OF CEMETERY OR CREMATORY Lane Cemetery 23D. LOCATION (City, town, or county) (State) Barstow, Md Cal. Co.

24A. DATE REC'D BY HEALTH DEPT. MAR 3 1967 24B. NAME OF REGISTRAR Robert E. Farkley 24C. FUNERAL DIRECTOR ADDRESS T.S. Hordeley, 12 Ridgely, Annapolis, Md

WILLIAMSON & CO

VALLEY ROAD

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------|---|------------------|--|---|
| BIRTH NO. 67 2117 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2117 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Lester Whitworth | | 2-28-1967 11:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | |
| 43 South Baltimore General Hospital | | Maryland Baltimore #21225 25-04 | | 500 Pontiac Ave. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| M | White | Married | 11-19-02 | 64 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Self Emp | | Grocery | | West Va. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Hiram Whitworth | | Cora Burton | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | Family Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 163X I | | (A) Pneumonia | | 48 hr | |
| ANTECEDENT CAUSES | | (B) Ca of lung (probable) | | years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (we) (this hospital) attended the deceased from 2-9 19 67 to 2-28 19 67, that (we) last saw the deceased alive on 2-28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Richard H. Reed | | | | 3-1-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Richard H. Reed | | 1213 Light St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 3/4/67 | | Cedar Hill Cem. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 3 1967 | | Philip E. Taylor | | McCully F H 237 Patapsco Ave 21225 | |

6119

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2118 | | CITY HEALTH DEPARTMENT | | Registered No. 67 2118 | |
|---|-------------------------|--|--|---|---|
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) (Balthauser) <u>WILLIAM B. FREDERICK MAX (HAX)</u> | | | 2. DATE AND HOUR OF DEATH 3/2/67 <u>MARCH 2, 1967 3:30 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE 18</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 18</u> | | |
| D. STREET ADDRESS (If rural, give location) <u>MARYLAND APTS. APTS.</u> | | | E. AGE (In years last birthday) <u>70</u> | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>08-05-96</u> | 9. AGE (In years last birthday) <u>70</u> | 10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE AGENT</u> | | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | 13. FATHER'S NAME <u>GEORGE A. MAX</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>AGUSTA E. WILKINS</u> (Augusta E. Wilkins) | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. <u>216-32-6949</u> | | | 17. INFORMANT <u>MRS. JEAN MAX (WIFE)</u> ADDRESS <u>Ambassador Apts., Balto., 18</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMATOSIS</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u> | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>CARCINOMA of prostate</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 YEARS</u> | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | |
| 21A. DATE OF OPERATION | | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. HOW DID INJURY OCCUR? | | |
| 21E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21F. HOW DID INJURY OCCUR? | | |
| 21G. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 15, 1967</u> to <u>MARCH 2, 1967</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 2, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>James W. Carty, Jr.</u> | | | 23B. DATE SIGNED <u>3/2/67</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>JAMES W. CARTY, JR., M.D.</u> | | | 23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | | 24B. DATE <u>Mar-4-67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>3801 Frederick Av-21229</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>MAR 3 1967</u> | | 24F. NAME OF REGISTRAR <u>Robert E. Taylor</u> | |
| 24G. FUNERAL DIRECTOR <u>Stewart & Mowen Co. 108-W-North-Av-21201</u> | | 24H. ADDRESS <u>Stewart & Mowen Co. 108-W-North-Av-21201</u> | | 24I. DATE <u>3/2/67</u> | |

C-455

67 2119

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2119

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LEE

COLEMAN

2. DATE AND HOUR PRONOUNCED DEAD

February 28, 1967

10:49 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

46 Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

617 N. Pulaski Street

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

Bro. R.R.

11. BIRTHPLACE (State or foreign country)

Wilson N.C.

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Jim Coleman

14. MOTHER'S MAIDEN NAME

MAGGIE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

240-22-9940

17. INFORMANT

ADDRESS

Gladys Coleman 535 N Calhoun St.

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

2/28/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/4/67

23C. NAME of CEMETERY or CREMATORY

Mt Auburn

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

MAR 3 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Marshall P. Hays 638 N. Calhoun St.

ADDRESS

Franklin P. Johnson
State of New York

IN SENATE
JANUARY 10, 1906
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1895

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2120 | |
|---|------------------|--|-----------------------------|--|--|
| BIRTH NO. 67 2120 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Madgie Johnson | | 2. DATE AND HOUR OF DEATH 2-20-67 1:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore, 18-02 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 18-02 | | | |
| | | D. STREET ADDRESS (If rural, give location) 1219 W. Fayette Street | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 75 yrs. | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS M's. Queen Hays - Guardian 226 Presstman St. | |
| 18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Uremia (B) DUE TO ASHD (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from February 14, 1967 to February 20, 1967, that (I) (we) last saw the deceased alive on February 20, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A. Khalig | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2-20-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. 1514 Division Street Balto., Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 2-24-67 | | 24C. NAME OF CEMETERY or CREMATORY | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD | |

Small

10/24

Small

Small

1
H-536

BALTIMORE CITY HEALTH DEPARTMENT

67 2121

BIRTH NO. 67 2121 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2121

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GEORGE HENDERSON 2. DATE AND HOUR PRONOUNCED DEAD 3-1-67 1:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1431 Stromeyer Way 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

april 8-1898

9. AGE (In years last birthday)

68

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

R.R.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

M.D.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

717-07-6405

17. INFORMANT

Mrs. Eleanor Henderson

ADDRESS

1431 Stromeyer Way

18. 422.1 X 260 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

XXXX

associated with diabetes mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK

NOT WHILE AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-1-67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

3-1-67

23C. NAME of CEMETERY or CREMATORY

Gardens of Faith

23D. LOCATION

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 3 1967

24B. NAME OF REGISTRAR

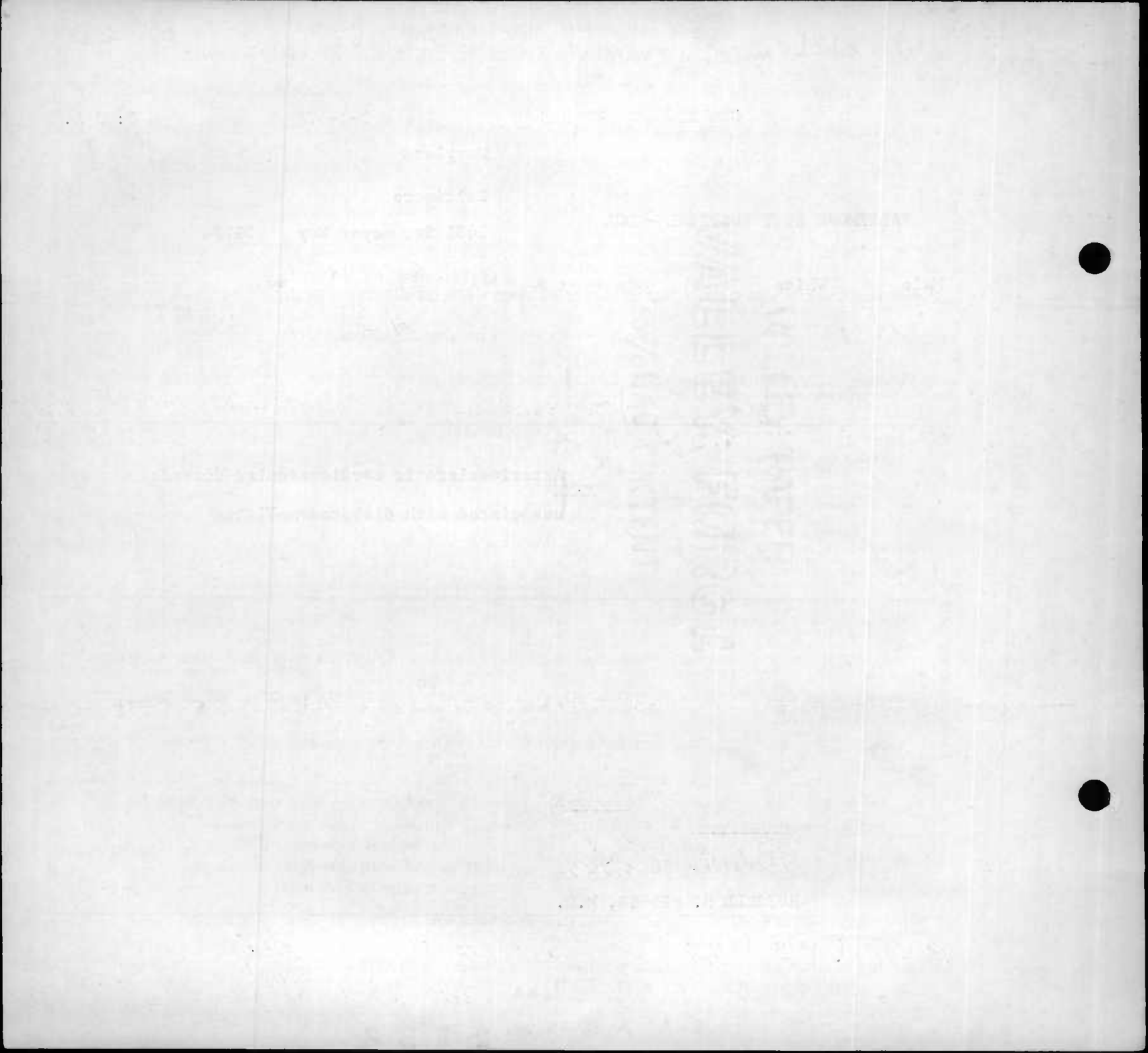
Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Shelmar A. Hoffmann

ADDRESS

3218 Hudson St.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|---|--|---|---|
| BIRTH NO. 67 2122 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2122 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Philip Amos Small</i> | | | |
| 2. DATE AND HOUR OF DEATH <i>28 Feb 1967</i> | | 6:30 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balts Co.</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University of Maryland Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 28</i> | | | |
| D. STREET ADDRESS (If rural, give location) <i>25 Briarwood Rd.</i> | | 53-00 | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>Caucasian</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>29 March 1904</i> | 9. AGE (In years last birthday) <i>62</i> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>SPORTING GOODS</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | 13. FATHER'S NAME <i>William Small</i> | | 14. MOTHER'S MAIDEN NAME <i>Underwood</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>213104325</i> | | 17. INFORMANT <i>Jo Lorraine Small</i> | |
| 18. ADDRESS <i>wife (Same)</i> | | 19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cardiorespiratory Arrest</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Ruptured Thoracic Aneurysm</i> | | 21. DATE OF OPERATION <i>21</i> | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 23. AUTOPSY? (Yes or No) <i>Yes</i> | | 24. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 28. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 29. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 30. HOW DID INJURY OCCUR? | |
| 31. I certify that (I) (this hospital) attended the deceased from <i>10 February</i> 19 <i>67</i> to <i>28 February</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>28 February</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 32. SIGNATURE <i>Dr. J. S. Sanford, M.D.</i> | | 33. ATTENDING PHYSICIAN <input type="checkbox"/> | | 34. MED. DIRECTOR <input type="checkbox"/> | |
| 35. PHYSICIAN'S NAME (Type) <i>Dr. J. S. Sanford</i> | | 36. ADDRESS <i>University of Maryland Hospital</i> | | 37. DATE SIGNED <i>28 Feb 1967</i> | |
| 38. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 39. DATE <i>3/3/67</i> | | 40. NAME OF CEMETERY or CREMATORY <i>MEADOWRIDGE</i> | |
| 41. LOCATION <i>HOWARD CO. MD.</i> | | 42. DATE REC'D BY HEALTH DEPT. <i>MAR 3 1967</i> | | 43. NAME OF REGISTRAR <i>E. S. MACNABB</i> | |
| 44. FUNERAL DIRECTOR <i>E. S. MACNABB</i> | | 45. ADDRESS <i>301 FREDERICK Rd</i> | | 46. CITY, TOWN, OR COUNTY <i>21228</i> | |

Dr. J. B. [unclear]

University of Maryland Hospital

23 February 1952

Re: [unclear] [unclear]

Gardner, [unclear]

1. [unclear] [unclear]

William [unclear]

Station [unclear]

Male [unclear]

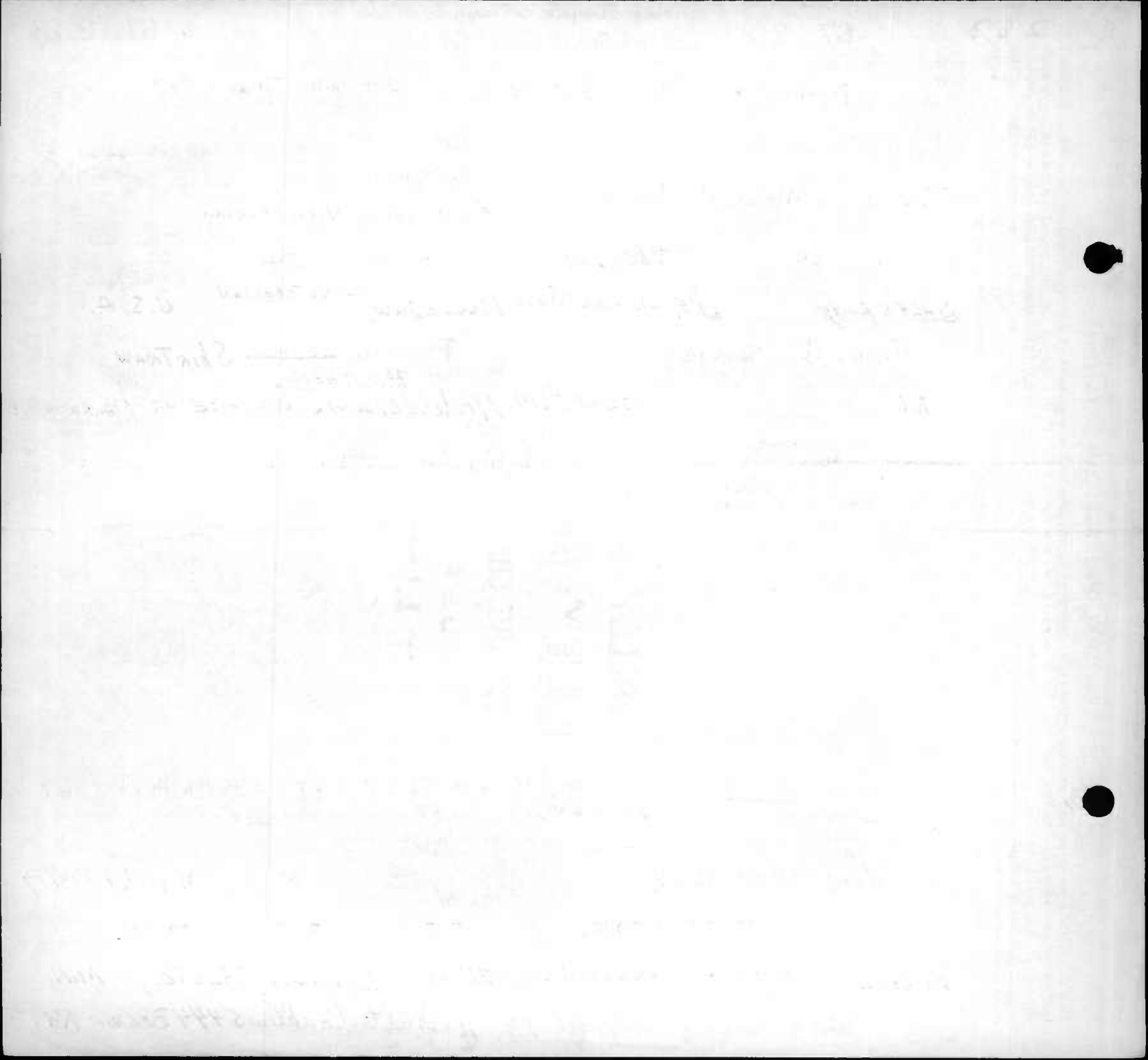
University of Maryland Hospital

23 February 1952
[unclear]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

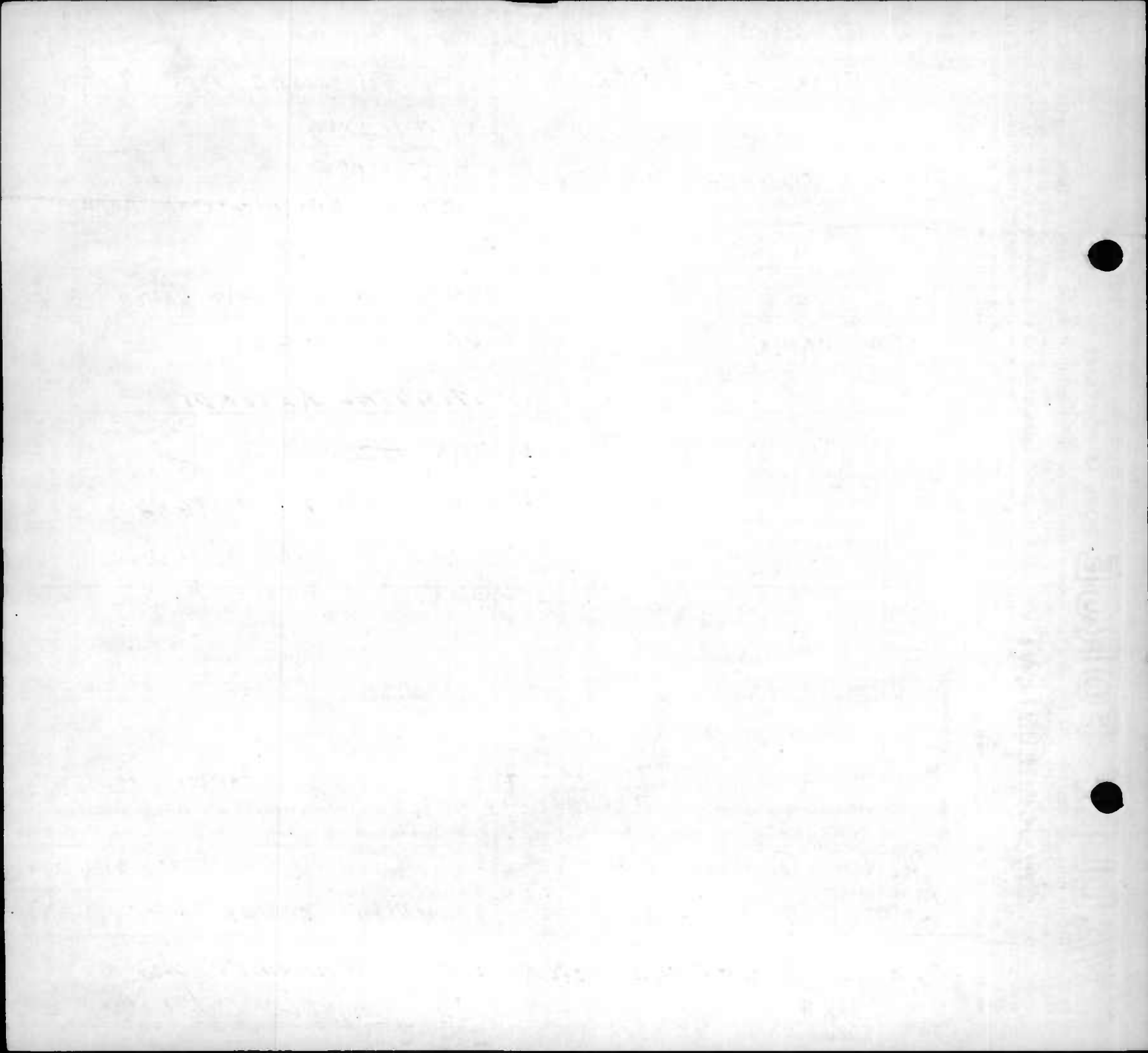
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------------------|--|---|--|---|
| BIRTH NO. 67 2123 | | CERTIFICATE OF DEATH | | 67 2123 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Richardson, Gladys Beatrice | | | 2.45 AM, Mar. 1. 1967 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital | | | A. STATE Md B. COUNTY | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 4203 Valley View Avenue | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED | 8. DATE OF BIRTH 05-01-12 | 9. AGE (In years last birthday) 54 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY | | 10B. KIND OF BUSINESS OR INDUSTRY DEPARTMENT STORE | | 11. BIRTHPLACE (State or foreign country) MOOSEJAW, SASKATCHEWAN | |
| 13. FATHER'S NAME Frederick Savage | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 122-01-5610 | | 17. INFORMANT BROTHER |
| | | | 17. INFORMANT ADDRESS MR. WILLIAM J. SAVAGE 4205 Parkwood Ave | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Lung Ca. | | | CAUSE OF DEATH Lung Ca. | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO (B) DUE TO (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10:30 pm Feb 28 1967 to 2:45 AM, Mar 1 1967 , that (I) (we) last saw the deceased alive on 2:45 AM Mar 1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sang Won Song | | | | 23B. DATE SIGNED March 1. 1967 | |
| 23C. PHYSICIAN'S NAME (Type) SANG WON SONG, | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-4-1967 | | 24C. NAME OF CEMETERY OR CREMATORY PARKWOOD CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) Taylor Ave, BALTO., Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1967 | | 25B. NAME OF REGISTRAR Robert S. Taylor | | 25C. FUNERAL DIRECTOR J. Walter Conklin 5444 BELAIR Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---|--|---|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2124 | | | | |
| BIRTH NO. 67 2124 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) BLANCHE DORSEY | | | | | 2. DATE AND HOUR OF DEATH February 27, 1967 9:40 M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL 36 | | | | | A. STATE MARYLAND | | | | |
| | | | | | B. COUNTY | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 18-03 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 107 S. ARLINGTON AVE | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH DEC. 25, 1900 | 9. AGE (In years last birthday) 66 | 10. Under 1 Yr. Months: Days: Hours: Min. | | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | | |
| 13. FATHER'S NAME IRA DANEN | | | | | 14. MOTHER'S MAIDEN NAME JANNIE MANN | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 215-16-6633 | | 17. INFORMANT ADDRESS HOSPITAL RECORDS | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH | | | | |
| | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | (A) ANEMIA, etc. | | | | |
| | | | | | (B) GASTROINTESTINAL BLEEDING | | | | |
| | | | | | (C) Carcinoma of uterine cervix C generalized metastases | | | | |
| | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from February 11, 1967 to February 27, 1967 , that (I) (we) last saw the deceased alive on FEBRUARY 27, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Josefina T. Naraval | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED FEBRUARY 27, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) JOSEFINA T. NARAVAL | | | | | 23D. ADDRESS FRANKLIN SQUARE HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | | 24D. LOCATION (City, town, or county) (State) | | |
| BURIAL | | 3/3/67 | | MEADOWRIDGE | | | HOWARD CO. MD | | |
| 25A. DATE REC'D BY HEALTH/DEPT. | | 25B. NAME OF REGISTRAR | | | 25C. FUNERAL DIRECTOR ADDRESS | | | | |
| MAR 3 1967 | | Robert E. Farley, M.D. | | | E. S. Nabb Catonsville, MD | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. B-200 67 2125 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2125 | |
|---|------------------|---|---|---|--|---|--|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Samuel Booze | | | | Feb. 24, 1967 6:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224 | | | | Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2806 W. Mulberry St. | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1-25-03 | 9. AGE (In years last birthday) 64 | 10. Under 1 Yr. Months: Days: | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour | | | 10B. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Isaah Booze | | | | 14. MOTHER'S MAIDEN NAME Henderson, Eleanor | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Ruth Booze - 2806 Mulberry St. # 21224 BCH: Records 4940 Eastern Ave. Baltimore, Md. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 162.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Bronchogenic Carcinoma DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from Dec 9 1966 to Feb 24 1967, that (1) (we) last saw the deceased alive on Feb 23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Alex Silverman | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Feb. 24, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) Alex Silverman | | | | 23D. ADDRESS M.D. Baltimore, City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-1-67 | | 24C. NAME OF CEMETERY OR CREMATORY Carnegie Mem. Park | | 24D. LOCATION (City, town, or county) (State) Laurel Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1967 | | 25B. NAME OF REGISTRAR R. E. E. E. E. | | 25C. FUNERAL DIRECTOR Gurnell G. Oden - Balto. Md | | ADDRESS | |

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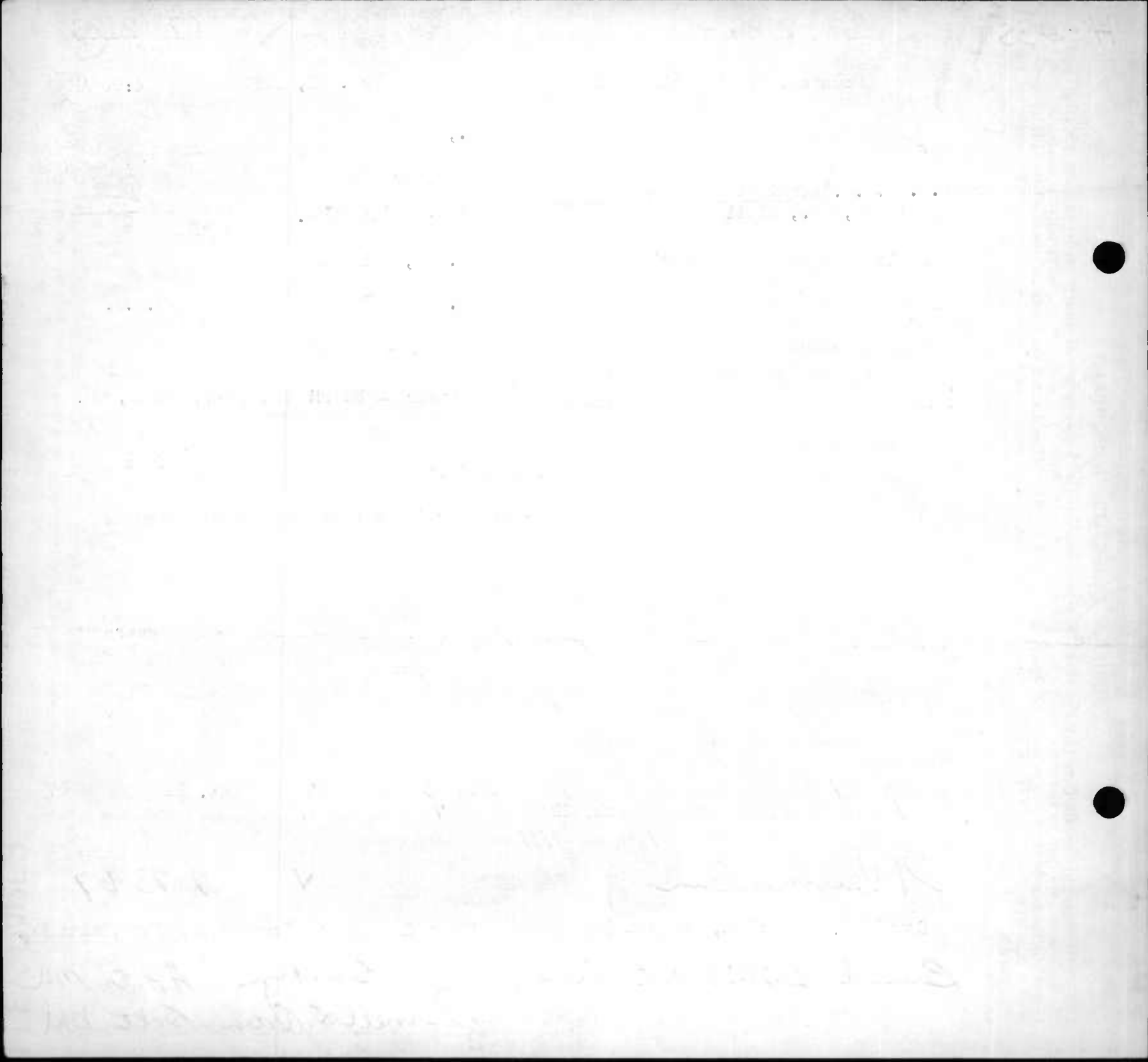
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2126 | |
|--|---------------|--|---|--|--|
| 67 2126 | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Houston, Sophia Elizabeth | | | | Feb. 22, 1967 4:05 AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION U.S. P.H.S. Hospital Baltimore, Md., 21211 | | | A. STATE Md., B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 25 D. STREET ADDRESS (If rural, give location) 316 Zeppelin Ave. | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Jul. 10, 1910 | 9. AGE (In years last birthday) 56 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Benjamin Odena | | | 14. MOTHER'S MAIDEN NAME Rachael Henson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) Pneumonitis days (B) Breast Carcinoma with metastases months (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Chronic Renal Disease years | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 25 1967 to Feb. 22 1967, that (I) (we) last saw the deceased alive on Feb. 22 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>G. Vermeulen</i> M.D. | | | | 23B. DATE SIGNED 2-23-67 | |
| 23C. PHYSICIAN'S NAME (Type) Gerald D. Vermeulen, Surgeon (R) M.D. | | | | 23D. ADDRESS US Public Health Service Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 2-25-67 | | 24C. NAME OF CEMETERY OR CREMATORY Mt Calvary | |
| 24D. LOCATION Brooklyn | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR ADDRESS | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1967 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|----------------------|--|--|---|--|--|---|--|--------------------------------|--|
| BIRTH NO. 67 2127 | | | | | CERTIFICATE OF DEATH | | Registered No. 67 2127 | | | |
| M.E. CASE NO. | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Harry F.W. Ray</i> | | | | | 2. DATE AND HOUR OF DEATH <i>Mar. 1/67</i> | | | | | |
| 3. PLACE OF DEATH <i>IN BALTIMORE, MARYLAND</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Gould Nursing Home</i> (If not in hospital or institution, give street address or location) <i>6116 Belair Rd</i> | | | | | A. STATE <i>Md.</i> | | | | | |
| | | | | | B. COUNTY <i>Baltimore</i> | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 1-02</i> | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>2728 Robinson St.</i> | | | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>W.</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i> | | 8. DATE OF BIRTH <i>Aug 28/86</i> | 9. AGE (In years last birthday) <i>80 yrs</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | |
| 13. FATHER'S NAME <i>Unknown</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <i>097-01-8536</i> | | 17. INFORMANT <i>Mrs. Elizabeth Simpson</i> | | ADDRESS <i>2728 Robinson St</i> | | |
| 18. <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral accident - stroke</i> | | | | | CAUSE OF DEATH (A) <i>Cerebral accident - stroke</i> | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 1, 1967</i> to <i>3/1/1967</i> , that (I) (we) last saw the deceased alive on <i>2/26 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <i>Joseph R. Liberto</i> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED <i>3/1/67</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>JOSEPH R. LIBERTO</i> | | | | | 23D. ADDRESS <i>350 S Beach St, Baltimore Md 41214</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>removal</i> | | | 24B. DATE <i>3/2/67</i> | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) <i>Phila Pa.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 3 1967</i> | | | 25B. NAME OF REGISTRAR <i>R. E. E. Taylor</i> | | | 25C. FUNERAL DIRECTOR <i>Philip Henry Sons</i> | | | ADDRESS <i>2024 Orleans St</i> | |

1000

1000

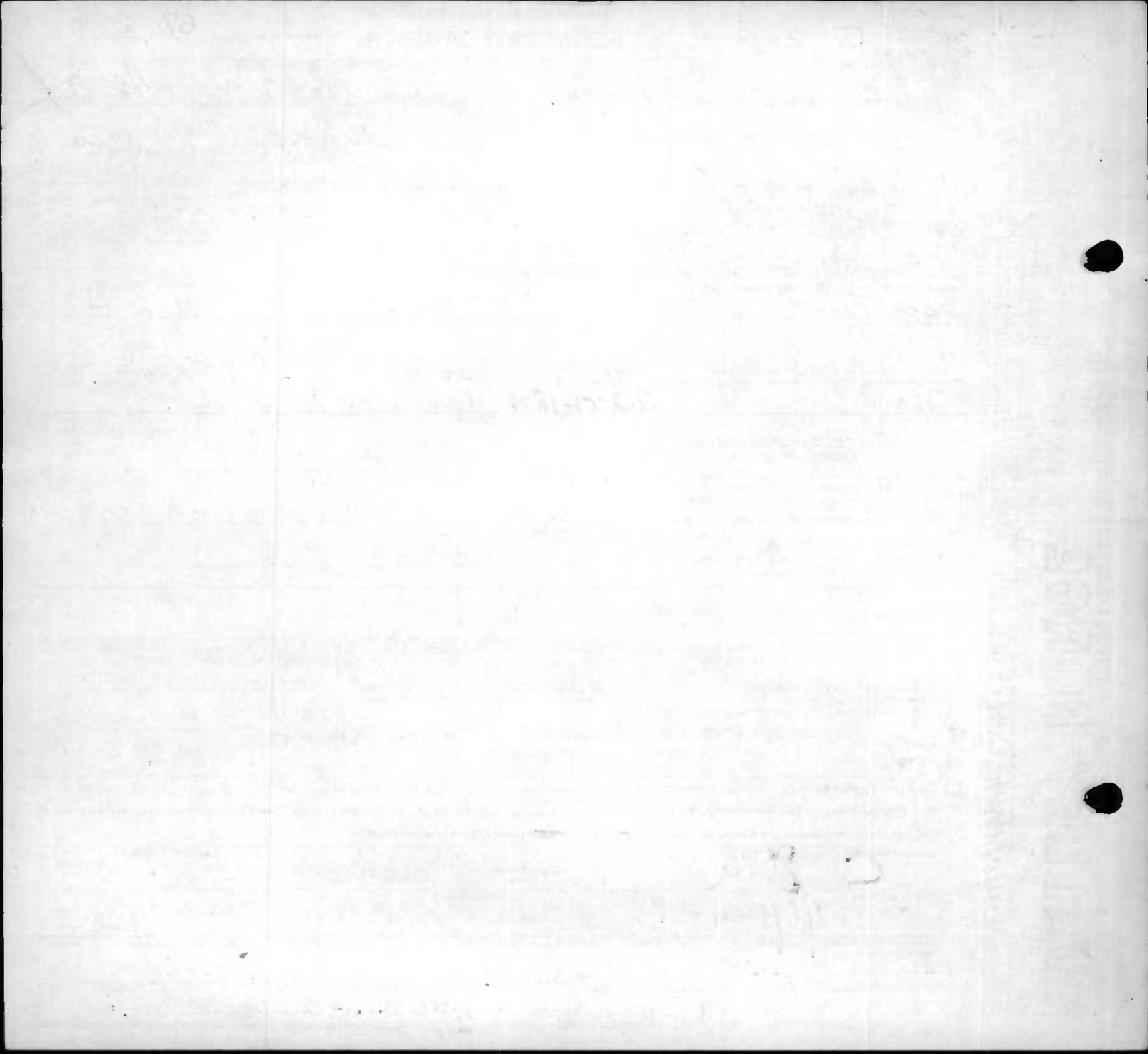
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FUNERAL DIRECTOR: IMPORTANT

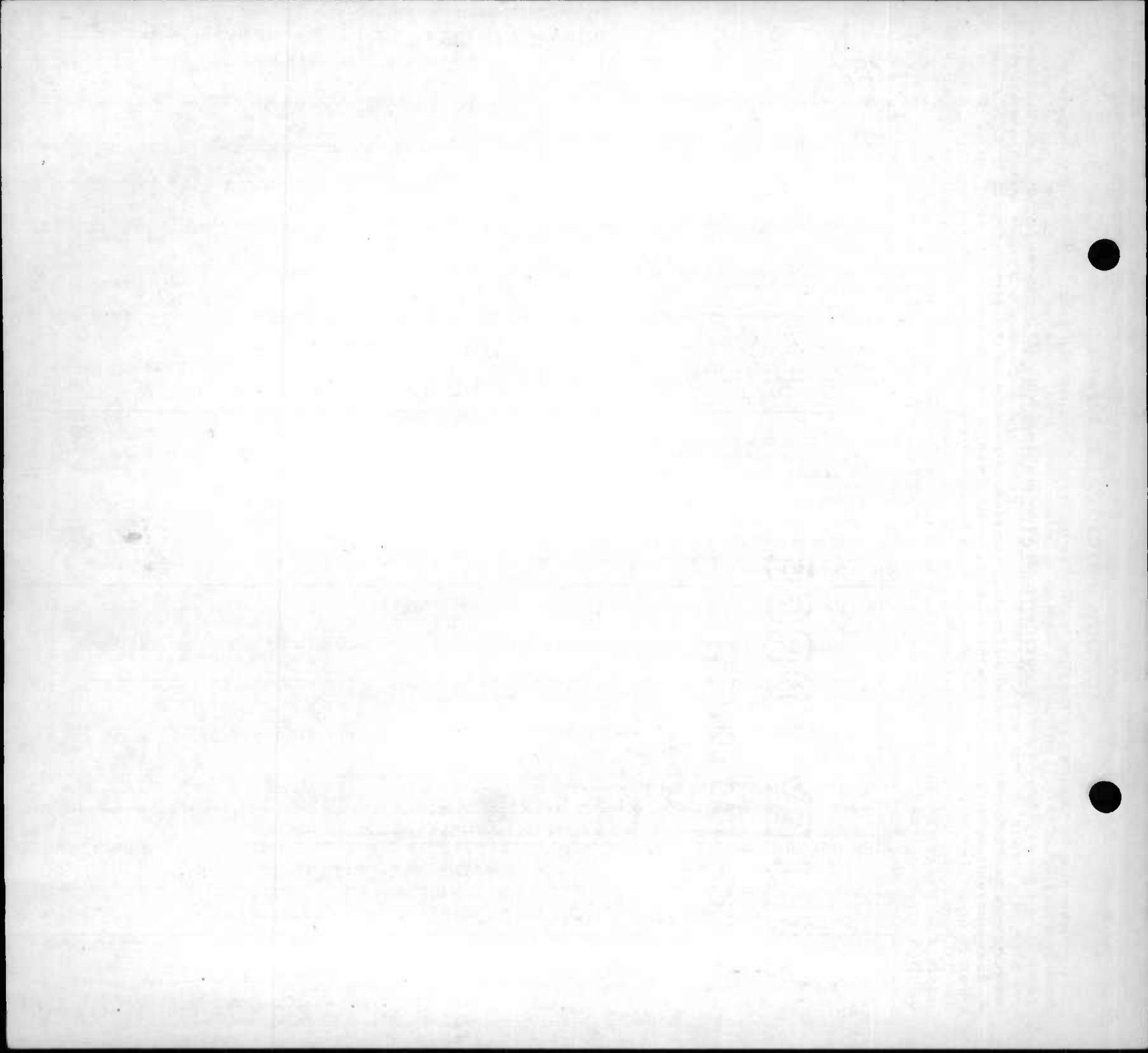
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2128 | |
|--|--|--|--|---|--|
| BIRTH NO. 67 2128 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Brennan, Mary</i> | | | |
| 2. DATE AND HOUR OF DEATH <i>2-28-67 4:35 A.</i> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>North General Hospital</i> | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | 5. SEX <i>Fe</i> 6. RACE <i>Cauc</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | 8. DATE OF BIRTH <i>5-14-06</i> 9. AGE (In years last birthday) <i>60</i> | | | |
| D. STREET ADDRESS (If rural, give location) <i>2687 West Park Dr.</i> | | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i> | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY <i>Arunde Fries Co.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | 13. FATHER'S NAME <i>Thomas Moore</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>Mary Williams</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | |
| 16. SOCIAL SECURITY NO. <i>212-01-1824</i> | | 17. Informant <i>Mary Brennan</i> ADDRESS <i>2687 Westpark Dr.</i> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) I. <i>Carcinoma of larynx</i> II. <i>Branchiopneumonia 5-10 days bilateral</i> | | 19. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) <i>bilateral</i> | | | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 22. I certify that (this hospital) attended the deceased from <i>1-14</i> 19 <i>67</i> to <i>2-28</i> 19 <i>67</i> , that (we) lost saw the deceased alive on <i>2-28</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) view the body after death. | | 23. DATE SIGNED <i>2-28-67</i> | | | |
| 24. SIGNATURE <i>C. Stille</i> | | 25. DATE SIGNED <i>2-28-67</i> | | | |
| 26. PHYSICIAN'S NAME (Type) <i>Ulfjohn</i> | | 27. ADDRESS <i>6821 Reisterstown Rd.</i> | | | |
| 28. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 29. DATE <i>3-3-67</i> | | | |
| 30. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cem.</i> | | 31. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | | |
| 32. DATE REC'D BY HEALTH DEPT. <i>MAR 3 1967</i> | | 33. NAME OF REGISTRAR <i>Witzke E.D.</i> | | | |
| 34. FUNERAL DIRECTOR ADDRESS <i>4101 Edmondson Ave.</i> | | 35. <i>212-01-1824</i> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

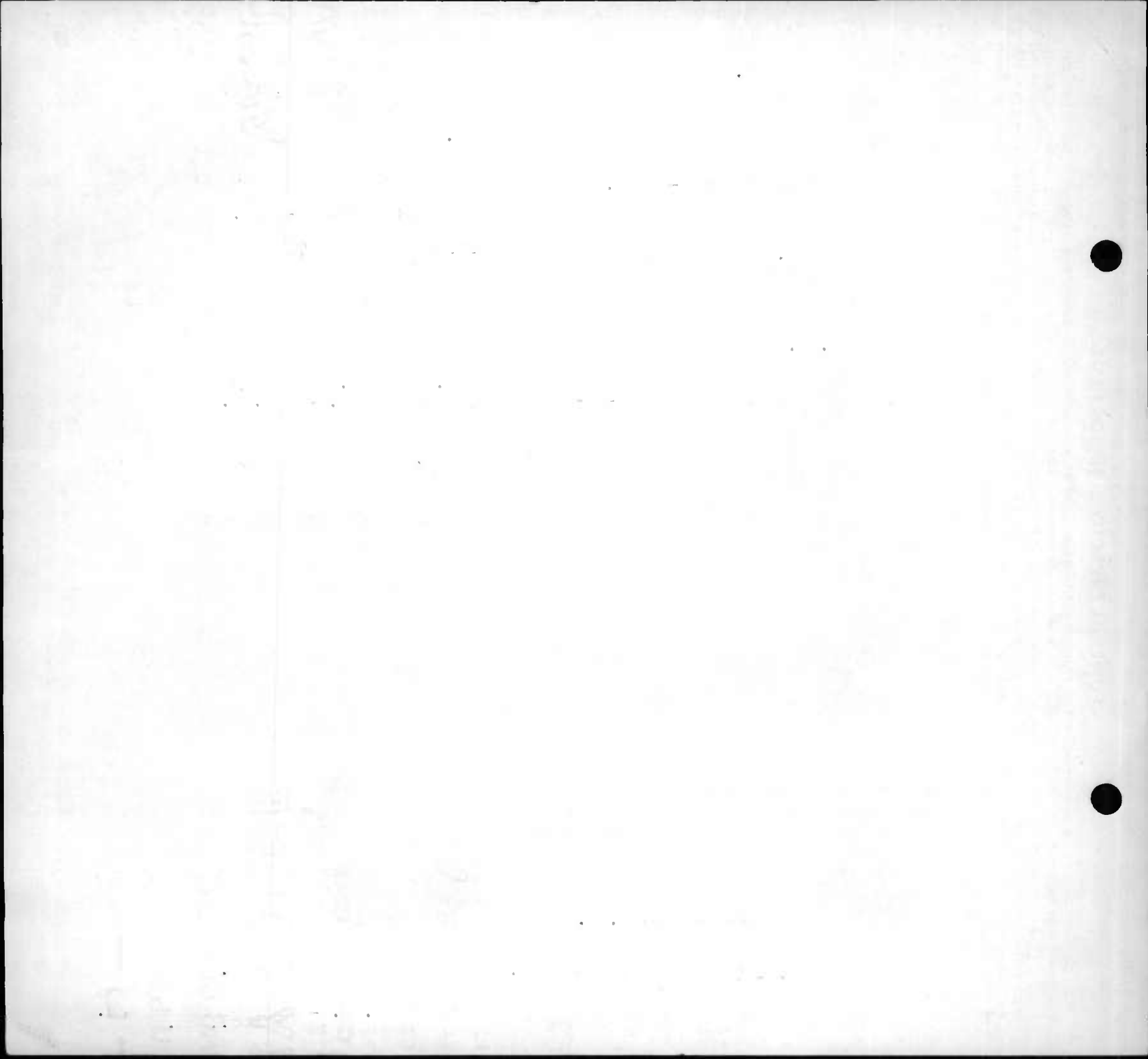
| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 67 2129 | |
|--|-------------------------|--|---|--|--|--|-----------------------|
| BIRTH NO. 4570 | | 67 2129 | | | | | |
| M.E. CASE NO. 67 2129 | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) EDWARD FORTUNE MILAN | | | | 2. DATE AND HOUR OF DEATH MARCH 1, 1967 2:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 613 WINANS WAY | | (If not in hospital or institution, give street address or location) | | A. STATE MD. BALTIMORE CITY | | B. COUNTY | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY | | D. STREET ADDRESS (If rural, give location) 613 WINANS WAY | | 28-04 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED MARRIED | 8. DATE OF BIRTH NOV 18, 1903 | 9. AGE (In years last birthday) 63 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME MATTHEW F. MILAN | | | | 14. MOTHER'S MAIDEN NAME MARY YAKIMUS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WORLD WAR II | | 16. SOCIAL SECURITY NO. 220-44-1711 | | 17. INFORMANT MARGARET MILAN | | ADDRESS 613 WINANS WAY | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) MYOCARDIAL INFARCTION | | IMMEDIATE | |
| | | | | (B) HYPERTENSIVE CARDIO-VASC. Dis. | | 1945 | |
| | | | | (C) CORONARY INSUFFICIENCY | | 1950 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JULY 1950 to MARCH 1 1967 , that (I) (we) last saw the deceased alive on FEB 21 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Albert R. Milan M.D. | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED MARCH 1 1967 | |
| 23C. PHYSICIAN'S NAME (Type) ALBERT R. MILAN M.D. | | | | 23D. ADDRESS 320 EAST 33RD. ST. BALTIMORE MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-6-67 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1967 | | 25B. NAME OF REGISTRAR Robert E. Jankyn | | 25C. FUNERAL DIRECTOR Witzke F. D. | | ADDRESS - 4101 Edmondson Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 67 2130 | |
|---|------------------|---|-----------------------------------|--|---|--|-------------------------------------|
| BIRTH NO. 67 2130 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) G. Harry Mc Cartney | | 2. DATE AND HOUR OF DEATH March 2, 1967 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 400 Athol Avenue - Apt. B | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 400 Athol Avenue - Apt. B | | | |
| 5. SEX M | 6. RACE Cauc. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9-7-92 | 9. AGE (in years last birthday) 74 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME W. H. McCartney | | | | 14. MOTHER'S MAIDEN NAME Maggie Lee | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I | | 16. SOCIAL SECURITY NO. 212-10-0859A | | 17. INFORMANT Mrs. Harry G. McCartney 400 Athol Ave. - Apt. B. | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) DUE TO Metastatic Carcinoma (B) DUE TO Rectal Adenocarcinoma (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 2 1967 to 1967, that (I) (we) last saw the deceased alive on MARCH 2 1967 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Melvin N. Borden M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED March 3, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) Melvin Borden, M. D. | | | | 23D. ADDRESS 5000 Baltimore National Pike | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-6-67 | | 24C. NAME OF CEMETERY or CREMATORY Holly Wood Cem. | | 24D. LOCATION (City, town, or county) (State) Richmond, Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1967 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave. Balto., Md. | | ADDRESS | |



1
M-200

| BIRTH NO. 67 2131 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2131 | |
|---|--------------------|--|-------------------------------|---|---|
| 1. NAME OF DECEASED (Type or Print) Paul Massey | | 2. DATE AND HOUR PRONOUNCED DEAD 2/27/67 8:40 p. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Hopkins Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1325 E. Fayette St. | | | |
| 5. SEX male | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widow | 8. DATE OF BIRTH 2-26-1921 | 9. AGE (In years last birthday) 47 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maritime Employed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Ridgeway S. Carolinoe | |
| 13. FATHER'S NAME Charlie Massey | | 14. MOTHER'S MARDEN NAME Hattie Jackson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Ruth M Booker Charlotte N.C. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.) E900.0 Craniocerebral injury | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) DUE TO | | (B) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1119 N. Patterson Pk. Ave. 8-04 | |
| 21D. TIME OF INJURY (APPROX.) 2 27 67 12:59a | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? fell down steps | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 2/28/67 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 3-3-67 | | 23C. NAME OF CEMETERY or CREMATORY Mt Auburn Cmt | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 3 1967 | | 24B. NAME OF REGISTRAR Robert E. Farley M.D. | | 24C. FUNERAL DIRECTOR Thoy C. Wilson 1000 Beantley Ave | |

MAINTENANCE REPORT

DATE

MAINTENANCE REPORT

5-342

67 2132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 67 2132

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN V. SADLER

2. DATE AND HOUR OF DEATH

3/2/67

11:05 AM

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)35 CHURCH HOME & HOSP
BALTO. 31. Md.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

6-01

D. STREET ADDRESS (If rural, give location)

131 N. POTOMAC ST #24

5. SEX

M

6. RACE

W

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

7/7/02

9. AGE (In years
last birthday)

64

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Lithographer

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Govern

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

JOHN SADLER

14. MOTHER'S MAIDEN NAME

ANNA SHELVA MUDRA

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

213-10-4290

17. INFORMANT

ADDRESS

Mrs. May H. Sadler 131 N. Potomac St

18.

I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

Pulmonary Embolism

(B) DUE TO

Carcinoma lung recurrent

(C)

INTERVAL BETWEEN
ONSET AND DEATH

15 hr

1 yr

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
WorkNot While
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/2 1967 to 3/2 1967.
that (I) (we) last saw the deceased alive on 3/2 1967 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Manner Fildmoss

M.D.

Attending
Phys.Med.
DirectorStaff
Phys.

23B. DATE SIGNED

3/2/67

23C. PHYSICIAN'S
NAME (Type)

23D. ADDRESS

M.D.

2 E Read St

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

3/6/67

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MAR 3 1967

Robert E. Fildmoss

John A. Moran, Inc. 3000 E. Balto. St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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G-650

| BIRTH NO. 67 2133 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2133 | | | |
|---|--|----------------------|--|---|--|--------------------------------------|--|---|--|------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Raymond Arthur Green | | | | 2. DATE AND HOUR PRONOUNCED DEAD 3/1/67 5:05 p. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 City Hospitals | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 930 N. Calvert St. | | | | 5. AGE (In years last birthday) 40 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | | |
| 5. SEX male | | 6. RACE white | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced | | 8. DATE OF BIRTH Oct. 9, 1926 | | 9. AGE (In years last birthday) 40 | | 10. CITIZEN OF WHAT COUNTRY? | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Battle Creek, Michigan | | | |
| 13. FATHER'S NAME Edward R. Greene | | | | 14. MOTHER'S MAIDEN NAME Grace Kath | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Farley Funeral Home | | | | 18. ADDRESS 100 Capital Ave., N. E. Battle Creek, Mich. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) no | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) marine terminal | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) S.S. John C Berth #7 - Dundalk Marine Terminal | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 3 1 67 4:15p. | | | | 21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? struck by truck which fell from broken cable | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 3/2/67 | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Removal | | | | 23B. DATE 3/3/1967 | | | | 23C. NAME of CEMETERY or CREMATORY Battle Creek, Michigan | | | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 3 1967 | | | | 24B. NAME OF REGISTRAR Robert E. Farley | | | | 24C. FUNERAL DIRECTOR Wm. J. Tichner & Sons | | | |
| 24D. ADDRESS Baltimore, Md. North & Pa. | | | | | | | | | | | |

WALLACE & GORRE

VALLEY SYSTEM

TRADING COMPANY



S-542

| BALTIMORE CITY HEALTH DEPARTMENT | | | |
|--|---------------------------|---|------------------------------------|
| BIRTH NO. <u>67 2134</u> | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. <u>67 2134</u> | |
| M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Theresa Samuels | | 2. DATE AND HOUR PRONOUNCED DEAD 3/2/67 7:15 a. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1008 Lamont Ave. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1008 Lamont Ave. | |
| 5. SEX female | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) child | 8. DATE OF BIRTH 11/1/66 |
| 9. AGE (In years last birthday) 4 | | 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Darlington S Carolina | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME James Samuels | | 14. MOTHER'S MAIDEN NAME Benzena Ham | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mr James Samuels, Jr | | ADDRESS | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Interstitial pneumonitis (SDII) (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/2/67 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 3/4/67 | |
| 23C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetry | | 23D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 3 1967 | | 24B. NAME OF REGISTRAR Robert E. Farley, M.D. | |
| 24C. FUNERAL DIRECTOR Adolphus Halstead | | ADDRESS 1206 W North Ave | |

19670002141

MAINTENANCE RECORD

DATE

TIME

PLACE

REMARKS

INITIALS

SIGNATURE

DATE

TIME

PLACE

REMARKS

INITIALS

SIGNATURE

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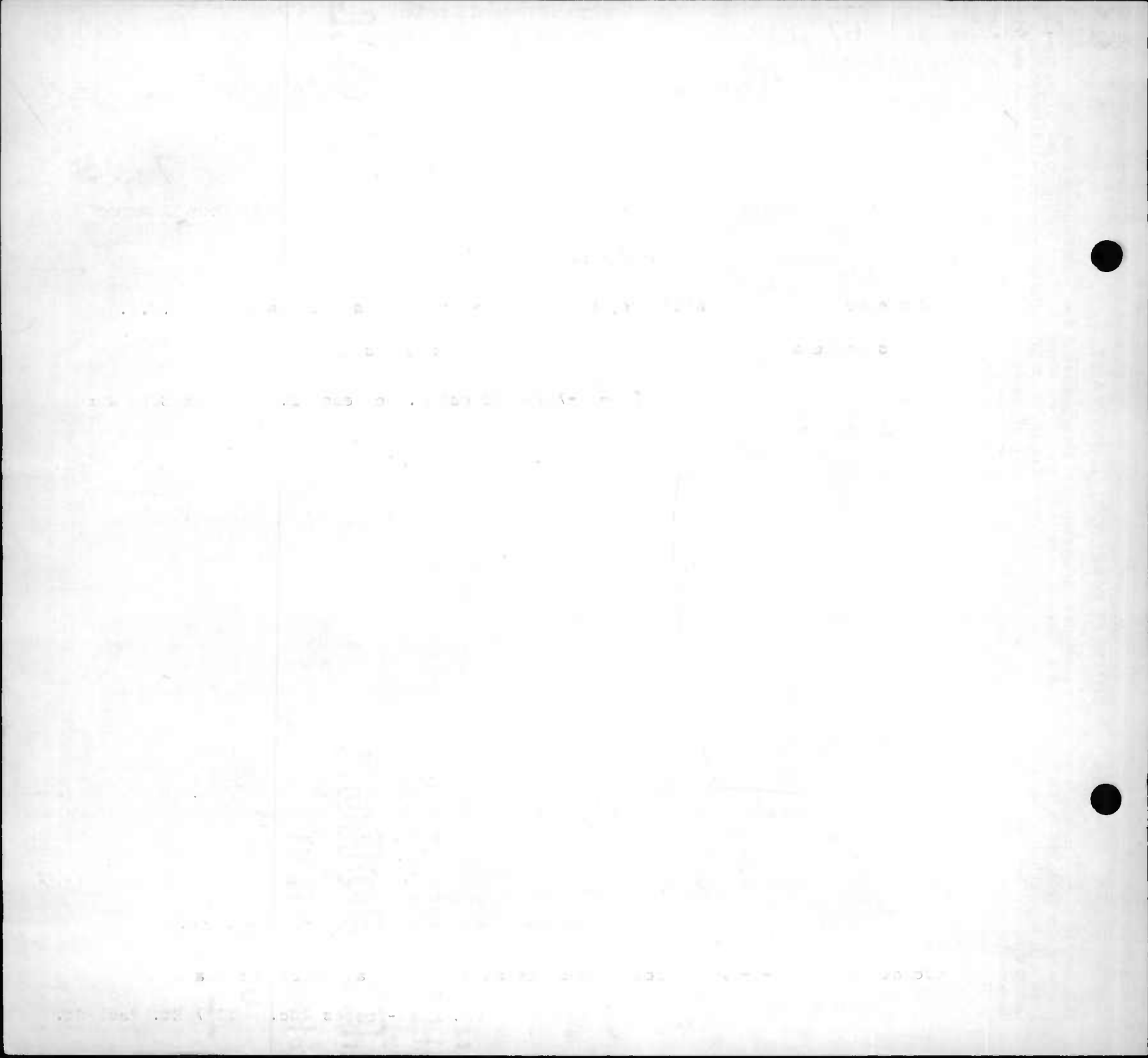
TIME

PLACE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|-----------------------------------|---|---------------------------------------|
| BIRTH NO. 67 2135 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2135 | |
| M-450 | | | | | |
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Mollema, Ernest | | | |
| 2. DATE AND HOUR OF DEATH | | 2/28/67 7:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 500 North Collington Avenue | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated | 8. DATE OF BIRTH 3/9/07 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surveyor | | 10B. KIND OF BUSINESS OR INDUSTRY Baltimore, City | | 11. BIRTHPLACE (State or foreign country) Oakland Mills, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Louis Mellema | | | |
| 14. MOTHER'S MAIDEN NAME Ella Simpson | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 218-10-7679 | | 17. INFORMANT ADDRESS Ernest R. Mellema Jr. 1807 Da Soto Road | | | |
| 18. 053,41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Gram negative sepsis & disseminated intravascular coagulation, seizures | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 1 week | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 2/21 19 67 to 2/28 19 67 that (I) (we) last saw the deceased alive on 2/28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David S. Fedson | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2-28-67 | |
| 23C. PHYSICIAN'S NAME (Type) David S. Fedson | | 23D. ADDRESS The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 3-1-67 | | 24C. NAME OF CEMETERY or CREMATORY Green Mount Crematory | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 3 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. 1217 St. Paul St. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2136 | |
|--|------------------|---|------------------------------|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 2136 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) ELEANORA JENSEN | | 2. DATE AND HOUR OF DEATH 3/1/67 6 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL | | A. STATE MARYLAND | | | |
| (If not in hospital or institution, give street address or location) | | B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 2-03 | | | |
| | | D. STREET ADDRESS (If rural, give location) 1620 Shakespeare Str. (31) | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED | 8. DATE OF BIRTH 6/8/1900 | 9. AGE (In years last birthday) 66 | 10. CITIZEN OF WHAT COUNTRY? U.S.A. AMERICAN |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (State or foreign country) POLAND | |
| 13. FATHER'S NAME JOSEPH SWISTEK | | 14. MOTHER'S MAIDEN NAME MARYANN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219 566470 | | 17. INFORMANT MARIE SHIRLEY GRUTKOWSKI (JENSEN) ADDRESS 5425 DAYWALT AVE 21206 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) MENINGIOMA of BRAIN (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 60 days. | | | |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2/2/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CRANIOTOMY | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/1/19 67 to 3/1/19 67, that (I) (we) lost saw the deceased alive on 3/1/19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Alfred T. Cox | | | | 23B. DATE SIGNED 3/1/67 | |
| 23C. PHYSICIAN'S NAME (Type) Alfred T. Cox | | | | 23D. ADDRESS M.D. CHURCH HOME & HOSP. FAYETTE & BROADWAY STS. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-4-67 | | 24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cem. | |
| 24D. LOCATION Balto. Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fairbank | | 25C. FUNERAL DIRECTOR Wm. Fialkowski 2007 Eastern Ave. Balto. Md. 21231 | | | |

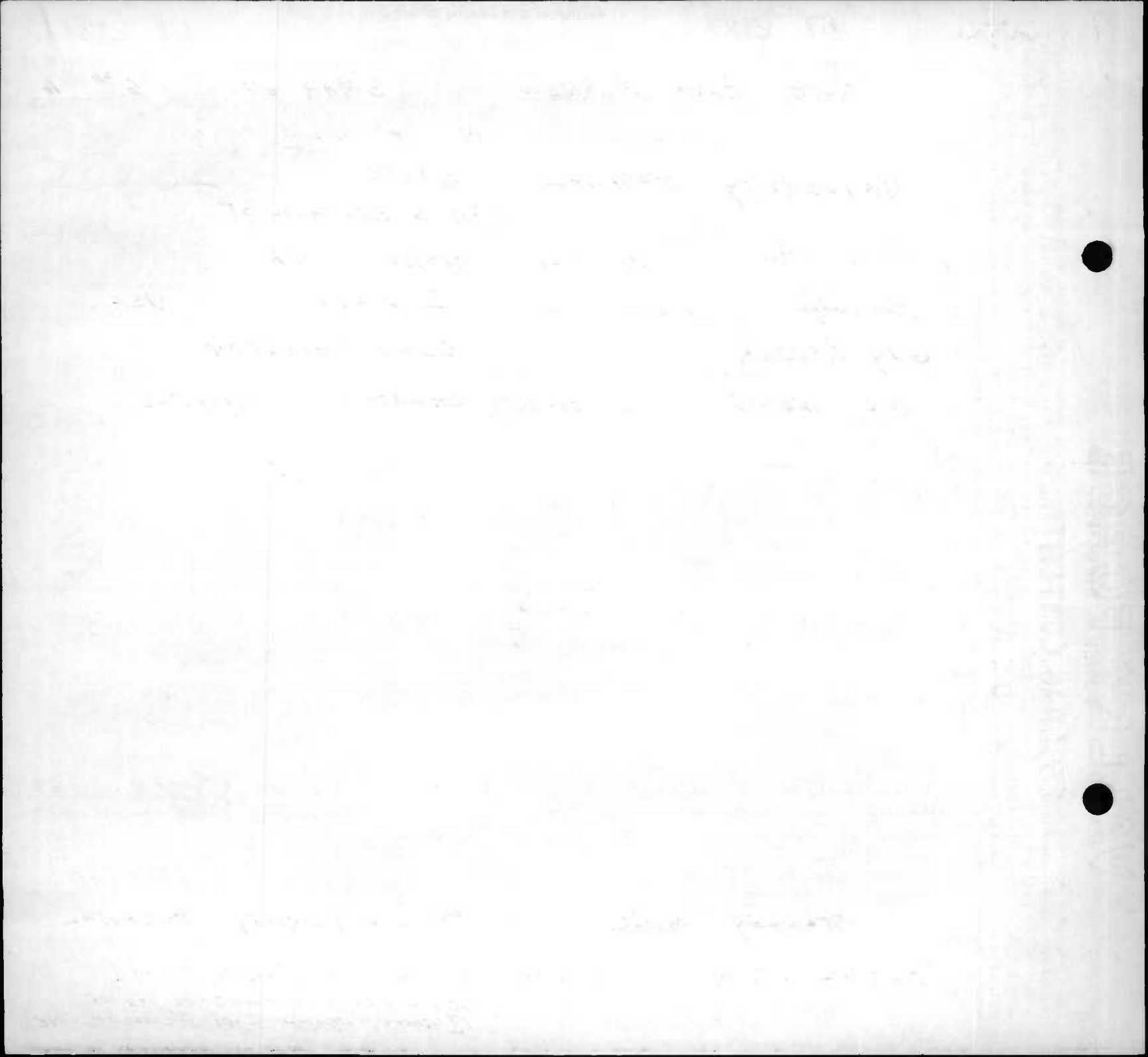
3/1/51

Alfred T. Cox
Alfred T. Cox

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2137</u> | |
|---|-----------------------|--|-----------------------------------|--|---|
| BIRTH NO. <u>67 2137</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>RUTH ANNA MCKNEW</u> | | 2. DATE AND HOUR OF DEATH <u>3 MAR 67</u> <u>6 30</u> A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MO.</u> B. COUNTY <u>BALTO CITY</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO.</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 UNIVERSITY HOSPITAL</u> | | D. STREET ADDRESS (If rural, give location) <u>211 S. BENTLEIGH ST.</u> | | 20-05 | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>CAU</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>4/3/10</u> | 9. AGE (In years last birthday) <u>56</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u> | | 11. BIRTHPLACE (State or foreign country) <u>INDIANA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>GUY REDDICK</u> | | 14. MOTHER'S MAIDEN NAME <u>CLEO THORNTON</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u> | | 16. SOCIAL SECURITY NO. <u>213-01-5075</u> | | 17. INFORMANT ADDRESS <u>CHART - Hospital</u> | |
| 18. <u>581-1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>CIRRHOSIS, RENAL FAILURE</u> DUE TO (B) <u>ALCOHOLISM</u> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>5 YEARS</u> <u>5 Days</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>CHF</u> | | | | <u>5 Days</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/27</u> 19 <u>67</u> to <u>3 MAR</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2 MAR</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Stanley Music</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>3 MAR 67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>STANLEY MUSIC</u> | | 23D. ADDRESS M.D. <u>70 UNIVERSITY HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3-7-67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE NATIONAL</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 6 1967</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>GEO. L. SCHWAB</u> <u>Funeral Home</u> <u>2101 Federal Ave.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | |
|---|--|--------------|--|--|----------------------|------------------------------------|--|--|--|---|--|--|--|---|--|
| BIRTH NO. 67 2138 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 2138 | | | | | |
| M.E. CASE NO. | | | | | | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) SILVESTRO, FRANK | | | | | | | | | | 3-3-1967 115 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South BALTIMORE GENERAL Hospital | | | | | | | | | | A. STATE MARYLAND | | | | | |
| | | | | | | | | | | B. COUNTY | | | | | |
| | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) 2137 TENROSE AVE. | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| MALE | | white | | NEVER MARRIED | | 9-15-84 | | 82 | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Retired Caulker | | | | city Gov't. | | | | ITALY | | | | U.S.A. | | | |
| 13. FATHER'S NAME CARMELLA Silvestro | | | | | | | | | | 14. MOTHER'S MAIDEN NAME Josephine Pometti | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | | | | | | | 16. SOCIAL SECURITY NO. 215-4F-8663 | | 17. INFORMANT ADDRESS Anthony Cocco 2137 Tenrose Ave. | | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE | | | | | | | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH MANY YEARS | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | | | | | | (B) DUE TO | | | | | |
| (C) DUE TO | | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 6 19 67 to mar. 3 19 67 , that (I) (we) last saw the deceased alive on mar. 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Harold A. Burnham M.D. | | | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED March 3 1967 | | | |
| 23C. PHYSICIAN'S NAME (Type) Harold A. Burnham M.D. | | | | | | | | | | 23D. ADDRESS South Baltimore Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | | | |
| Burial | | | | 3-7-67 | | NEW Cathedral | | | | BALTIMORE, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | | 25B. NAME OF REGISTRAR Robert E. Jackson | | | | 25C. FUNERAL DIRECTOR GEORGE L. Schwab FUNERAL HOME | | | | ADDRESS 2101 Frederick Ave. | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2139 | |
|--|-------------------------|--|------------------------------------|--|---|
| BIRTH NO. 67-04396 67 2139 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BABY BOY AYRES | | 2. DATE AND HOUR OF DEATH 3/2/67 7:50 AM. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY UNIVERSITY HOSPITAL | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. MD 21-02 | | | |
| 38 | | D. STREET ADDRESS (If rural, give location) 819 Washington Blvd. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 2/28/67 | 9. AGE (In years last birthday) 1 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. 1 10 25 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME NORMAN AYRES | | 14. MOTHER'S MAIDEN NAME ELEANOR CANTER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS ELLIOT S. TOKAR MD. | |
| 18. 773.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HYALINE MEMBRANE DIS. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1 day 1 hour | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 3/1/67 19 to 3/2/67 19, that (1) (we) last saw the deceased alive on 3/2/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Elliot S. Tokar | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/2/67 | |
| 23C. PHYSICIAN'S NAME (Type) ELLIOT S. TOKAR | | 23D. ADDRESS UNIVERSITY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-3-67 | | 24C. NAME OF CEMETERY or CREMATORY GLEN HAVEN | |
| 24D. LOCATION (City, town, or county) (State) GLEN BURNIE, MD | | 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Geo. L. Schwab FUNERAL HOME | | | |
| | | 25D. ADDRESS 2101 Frederick Ave. | | | |

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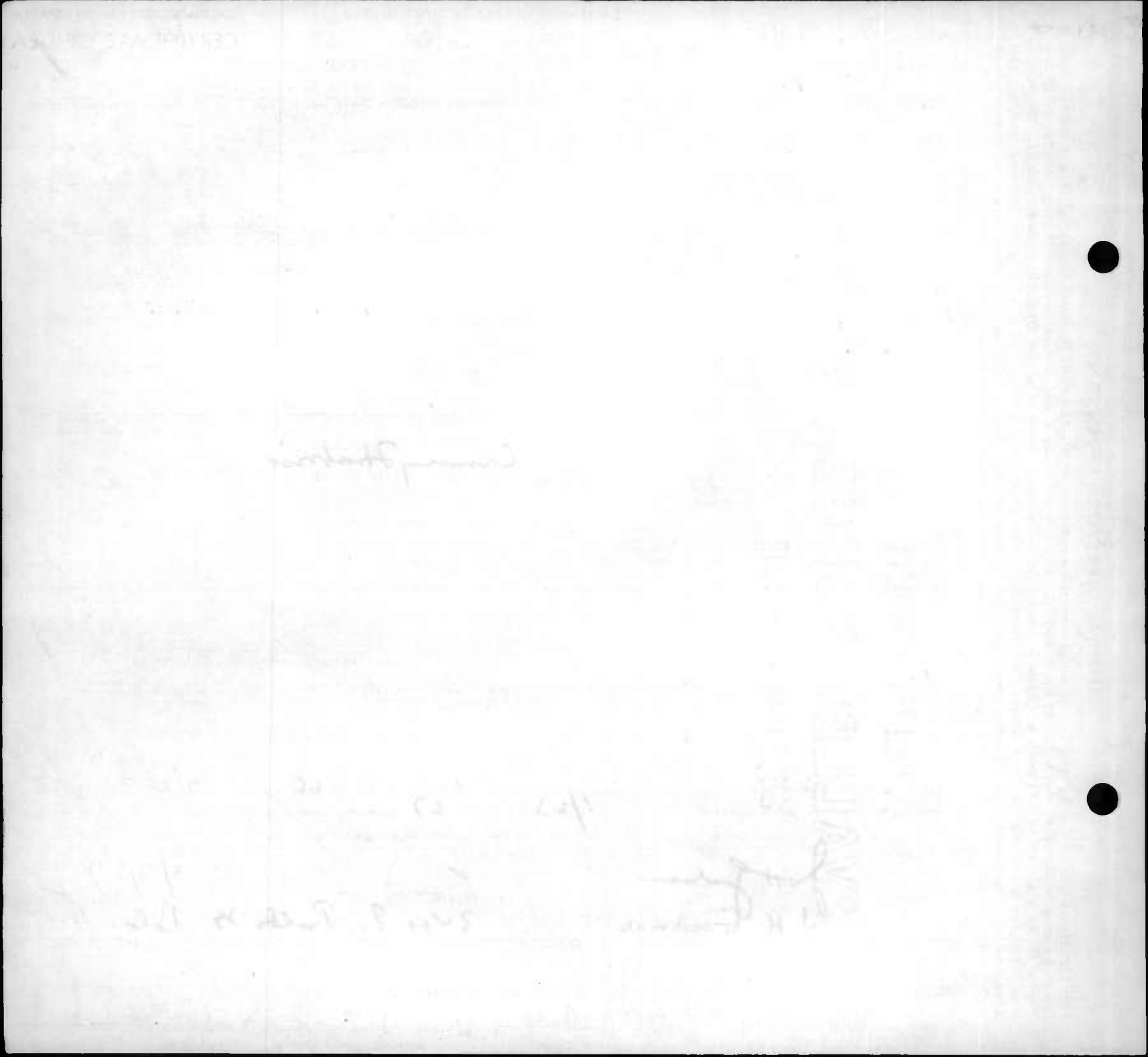
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 67 2140 | |
|--|------------|--|--------------------------|--|--|
| BIRTH NO. 67 2140 | | CERTIFICATE OF DEATH | | Registered No. 67 2140 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Daniel F. Naus | | 2. DATE AND HOUR OF DEATH March 2, 1967 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospital Baltimore, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3729 E. Lombard Street | | | |
| 5. SEX M | 6. RACE W. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9/17/10 | 9. AGE (In years last birthday) 56 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Toolmaker |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Toolmaker | | 10B. KIND OF BUSINESS OR INDUSTRY Edgewood Arsenal | | 11. BIRTHPLACE (State or foreign country) Berwick, Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Wm. F. Naus | | 14. MOTHER'S MAIDEN NAME Sarah Lunger | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 160-05-9198 | | 17. INFORMANT Mrs. Irene Naus | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO Carcinoma of the Colon | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/23 1966 to 3/2 1967, that (I) (we) last saw the deceased alive on 1/23 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. H. Goodman | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/3/67 | |
| 23C. PHYSICIAN'S NAME (Type) J. H. Goodman | | 23D. ADDRESS 3400 E. Belts Rd. Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/5/67 | | 24C. NAME OF CEMETERY or CREMATORY opp fellows Cem. | |
| 24D. LOCATION Danville, Pa. | | 24E. FUNERAL DIRECTOR Joseph H. Zimino | | 24F. ADDRESS 263 S. Conklin | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR J. H. Goodman | | 25C. ADDRESS 263 S. Conklin | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2141 | |
|---|---------------------|--|-----------------------------------|---|---|
| BIRTH NO. 67 2141 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) GEE NED | | 2. DATE AND HOUR OF DEATH 3-X-67 7:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital | | A. STATE MD | | B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | 13-02 | |
| | | D. STREET ADDRESS (If rural, give location) 2128 MT ROYAL TERR | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 6-3-05 | 9. AGE (In years last birthday) 61 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian Bethlehem Steel Co. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) VA, Lunnenburg City Va. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Thomas Gee | | 14. MOTHER'S MAIDEN NAME Henrietta Watson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 216-10-5169 | | 17. INFORMANT Marie Gee 2128 Mt Royal Terr | |
| 18. CAUSE OF DEATH 205X I | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MULTIPLE MYELOMA | | INTERVAL BETWEEN ONSET AND DEATH 9 YR | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 2-10-1967 to 3-X-1967 that (I) (we) lost saw the deceased alive on 3-X-1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Gordon | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3-X-67 | |
| 23C. PHYSICIAN'S NAME (Type) D. S. Gordon | | 23D. ADDRESS Sinai Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial March 9/67 | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | |
| 24D. LOCATION (City, town, or county) (State) Arbutus, Md. | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robert E. Johnson | |
| 25C. FUNERAL DIRECTOR Joseph E. Johnson | | ADDRESS 1129 N. Carlton St | | | |

MAR 6 1967

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|---|--|--|--|---|-------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2142 | | | | |
| BIRTH NO. 67 2142 | | M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) William Coosenberry | | | | | 2. DATE AND HOUR OF DEATH 3.2.67 11:07 | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE, 13 C. CITY OR TOWN (If outside city limits, write RURAL and give township) 8-03 D. STREET ADDRESS (If rural, give location) 2807 E. FEDERAL ST. | | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) DIVORCED | | 8. DATE OF BIRTH MAY 11, 1909 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Beaumont Virginia | | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME THORNTON Coosenberry | | | 14. MOTHER'S MAIDEN NAME Nina ? | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Bertha Lipon 2807 E. Federal St | | | ADDRESS | | | |
| 18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Pneumonia (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO (B) DUE TO (C) DUE TO | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2.27.66 19 to 3.2.67 19, that (I) (we) lost saw the deceased alive on 3.2.67 19 and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (<u>did</u>) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Robert M. Winslow M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 3.2.67 | |
| 23C. PHYSICIAN'S NAME (Type) Robert M. Winslow M.D. | | | | | 23D. ADDRESS Johns Hopkins Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE March 6/67 | | 24C. NAME OF CEMETERY or CREMATORY St. Stephens Cemetery | | 24D. LOCATION (City, town, or county) (State) Essex, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Edgar E. Johnson | | | 25C. FUNERAL DIRECTOR Malcolm E. Johnson | | | ADDRESS 11297, Central St | |

Robert C. Brown
Hill
Hill 22075

to be played
on Sunday

VS 150-REV. 1

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom.

2. In the second part, the author discusses the results of the experiments of Rutherford and his colleagues, which have shown that the atom is not a homogeneous mass, but is composed of a central nucleus and a surrounding cloud of electrons.

3. The third part of the paper is devoted to a discussion of the results of the experiments of Bohr and his colleagues, which have shown that the electrons in the atom are arranged in discrete orbits, and that the energy of the atom is quantized.

4. In the fourth part, the author discusses the results of the experiments of Heisenberg and his colleagues, which have shown that the position and momentum of a particle cannot be known simultaneously with arbitrary accuracy.

5. The fifth part of the paper is devoted to a discussion of the results of the experiments of Schrödinger and his colleagues, which have shown that the wave function of a particle can be used to calculate the probability of finding the particle in a given region of space.

6. In the sixth part, the author discusses the results of the experiments of Dirac and his colleagues, which have shown that the Dirac equation can be used to describe the behavior of particles with spin.

7. The seventh part of the paper is devoted to a discussion of the results of the experiments of Pauli and his colleagues, which have shown that the Pauli exclusion principle applies to particles with spin.

8. In the eighth part, the author discusses the results of the experiments of Fermi and his colleagues, which have shown that the Fermi-Dirac statistics apply to particles with spin.

9. The ninth part of the paper is devoted to a discussion of the results of the experiments of Einstein and his colleagues, which have shown that the Einstein-Bose statistics apply to particles with spin.

10. In the tenth part, the author discusses the results of the experiments of Planck and his colleagues, which have shown that the Planck distribution law applies to the energy of a black body.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2144 | |
|---|---------------------|--|------------------------------------|---|---|
| BIRTH NO. 67 2144 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED Carmella (Type or Print) Carmela G. Eberle | | 2. DATE AND HOUR OF DEATH March 2, 1967 5:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital | | D. STREET ADDRESS (If rural, give location) 2843 Lake Ave | | 8-01 | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 7/25/18 | 9. AGE (In years last birthday) 48 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) building maintenance | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME Anthony De Maggio | | 14. MOTHER'S MAIDEN NAME Isabelle Butera | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT ADDRESS Howard Eberle, husband, above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 170XY-E95IX | | CAUSE OF DEATH (A) DUE TO Carcinoma of breast (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 8 months | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. serum hepatitis | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from Feb 20 19 67 to March 2 19 67 , that (I) (we) last saw the deceased alive on March 2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE H. M. Morris | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/2/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/6/67 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Carmel Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR Robert E. Farley | |
| 25C. FUNERAL DIRECTOR Schimunek Funeral Home | | 25D. ADDRESS 3331 Brehms Lane #13 | | | |

University Hospital

March 2 1943

Feb 26 1943

serum hepatitis

Continued at front

Transill button

Harvard

April 1943

28th case

1st case

21

fasted to study

building maintenance

F W married

University Hospital

T-460

67 2145

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2145

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Louis L. Taylor

2. DATE AND HOUR PRONOUNCED DEAD

2/28/67 11:30 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2109 XXXX Wilkens Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 9, 1909

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Druid Park Motors

11. BIRTHPLACE (State or foreign country)

Hotsprings Va.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Russell B. Taylor

14. MOTHER'S MAIDEN NAME

Edna C. Mayse

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212-07-5588

17. INFORMANT

ADDRESS 21223

Mrs. Alma D. Taylor 2109 Wilkens Ave. Balto. Md/.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic cardiovascular disease
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

2/28/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

March 4, 1967

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cem.

23D. LOCATION

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 6 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

G. Truman Schwab 3512 Frederick Ave. Balto. Md.

ADDRESS

WALLLEY BOKGE

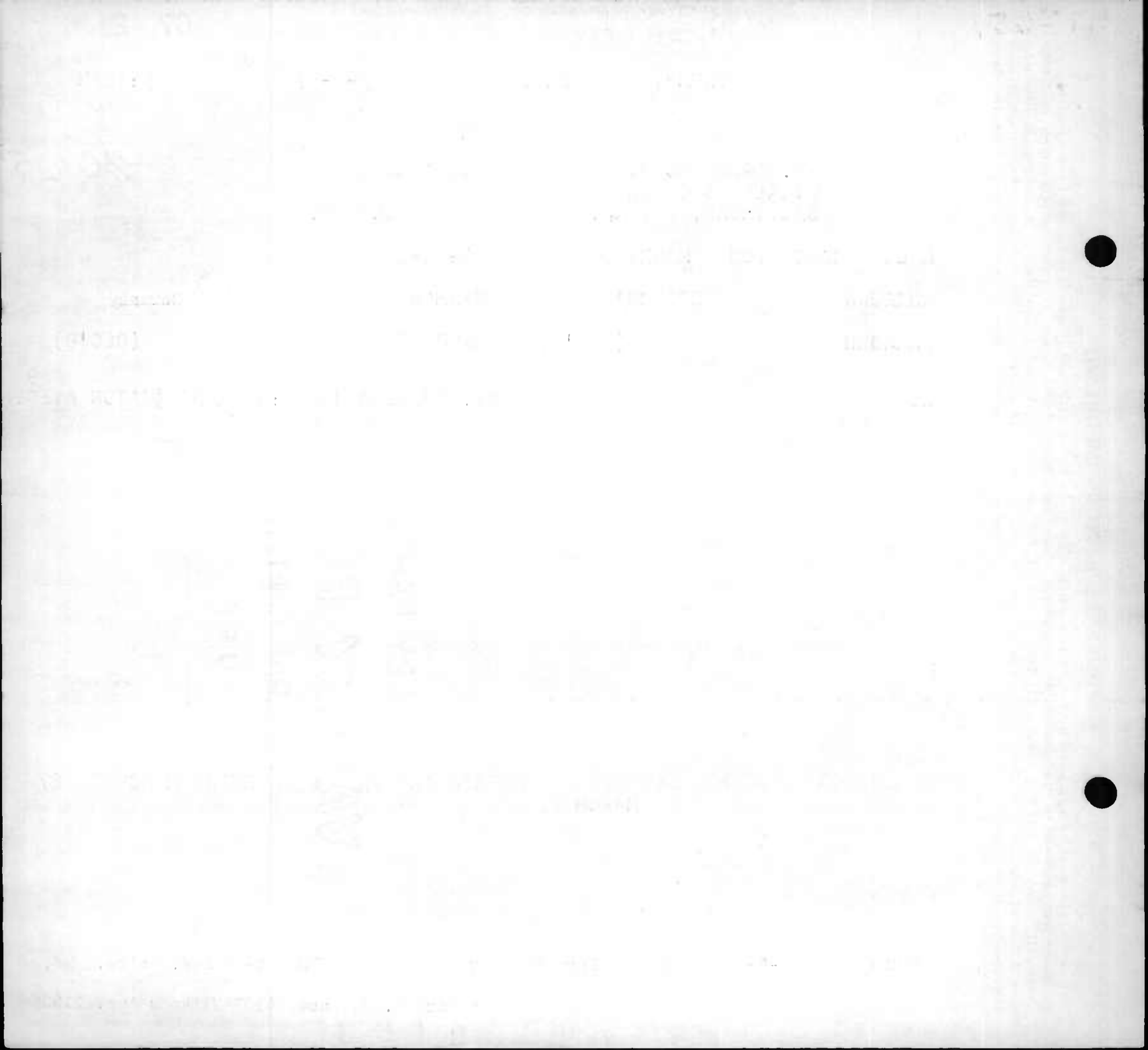
WALLLEY BOKGE

WALLLEY BOKGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. <u>67 2146</u> | |
|--|-----------------------------|---|--|--|--|--|--|--|------------------|-------------------------------|--|
| BIRTH NO. <u>67 2146</u> | | CERTIFICATE OF DEATH | | | | | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>TRUMP, CARL</u> | | | | 2. DATE AND HOUR OF DEATH <u>3-2-67</u> <u>5:15AM</u> M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) <u>ST. AGNES HOSPITAL WILKENS & CATON AVES BALTIMORE, 29, MD.</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) <u>2600 COLE ST.</u> | | | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>CAUCASION</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | | 8. DATE OF BIRTH <u>04-14-86</u> | | 9. AGE (In years last birthday) <u>80</u> | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u> | | 11. BIRTHPLACE (State or foreign country) <u>GERMANY</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>Germany</u> | | | |
| 13. FATHER'S NAME <u>UNKNOWN (DEC'D)</u> | | | | 14. MOTHER'S MAIDEN NAME <u>AUGUSTA (DEC'D)</u> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>ST. AGNES RECORDS: WILKENS & CATON AVES. #29</u> | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular accident</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>FEBRUARY 23</u> 19 <u>67</u> to <u>MARCH 2</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MARCH 2</u> , 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <u>S. Korbuly</u> M.D. | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type) <u>S. KORBULY</u> | | | | | | 23D. ADDRESS M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-6-1967</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>3801 Frederick Ave. Balto., Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 6 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u> | | ADDRESS <u>4107 Wilkens Ave. 21229</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 2147 | |
|---|--|--|--|--|--|--|--|---------------------------------|--|--|--|
| BIRTH NO. 67 2147 | | CERTIFICATE OF DEATH | | | | | | | | | |
| M.E. CASE NO. | | last name first name | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | RAYMOND, STANLEY | | | | 2-28-67 | | | | 11:45 PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | | A. STATE B. COUNTY | | | | | |
| ST. AGNES HOSPITAL WILKENS & CATON AVES BALTIMORE 29, MD. | | | | | | MD BALTO. 29 | | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | | | BALTIMORE 20-08 | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | | | 4209 POTTER ST. | | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| MALE | | CAUCASION | | DIVORCED | | 01 16 89 | | 78 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | |
| TAILOR-RETIRED | | | | | | LITHUANA | | | | U.S.A. | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| UNKNOWN (DEC'D) | | | | | | UNKNOWN (DEC'D) | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| | | | | 216 079866 | | ST. AGNES RECORDS: WILKENS & CATON AVE #29 | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (A) DUE TO | | | | Severe chronic emphysema, defective | |
| | | | | | | (B) DUE TO | | | | chronic congestive heart failure | |
| | | | | | | (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | Int. obstruction, relieved | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | Int. abd. | | NO | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 11 19 67 to FEBRUARY 28 19 67, that (I) (we) last saw the deceased alive on FEBRUARY 28 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Vincent G. Rubin M.D. | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3-1-67 | | | |
| 23C. PHYSICIAN'S NAME (Type) VINCENT RUBIN | | | | | | 23D. ADDRESS M.D. ST. AGNES HOSP CATON AND WILKENS #21229 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | | | |
| CREMATION | | 3-4-1967 | | Loudon Park Cemetery | | 3801 Frederick Ave., Balto., Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | | |

3/7/67 - Date of operation 3/12/67 -
operation received in plain ball
in the open camp. 9c

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FUNERAL DIRECTOR: IMPORTANT

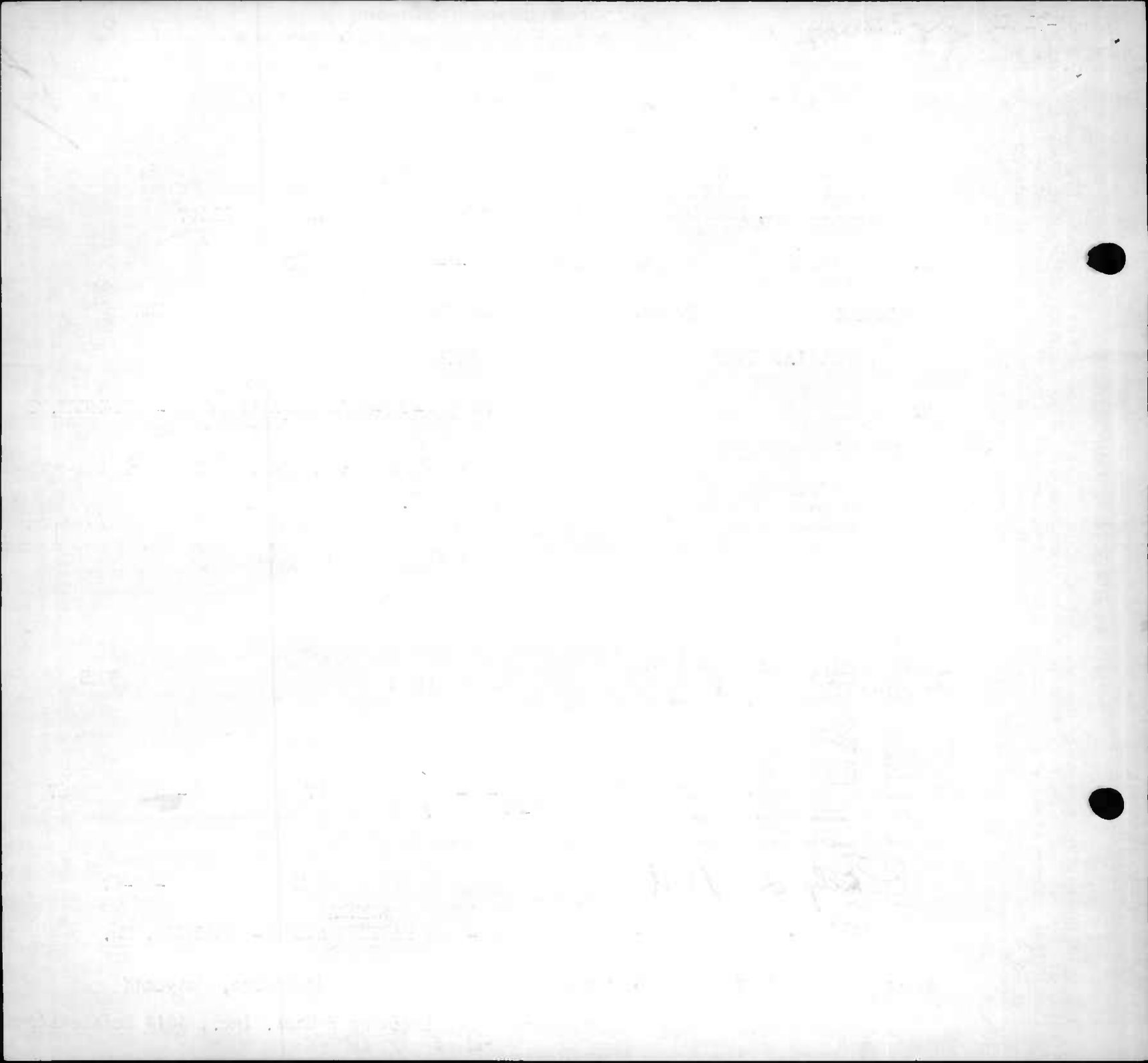
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2148</u> | |
|---|-------------------------|--|------------------------------------|--|---|
| BIRTH NO. <u>67 2148</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>FRANK COHEN</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>2-27-67</u> <u>10:30 P.M.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>91 Levindale Aged Home</u> | | A. STATE <u>Md.</u> B. COUNTY <u>BALTIMORE</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>27-17 Belvedere at Green Spring, Baltimore Md. INFIRMARY</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED <u>WIDOWER</u> | 8. DATE OF BIRTH <u>9/6/867</u> | 9. AGE (In years last birthday) <u>99</u> | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee - Nat'l Plastics</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Riga (Latvia)</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>PAUL COHEN</u> | | 14. MOTHER'S MAIDEN NAME <u>Yetta ?</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | | 17. INFORMANT <u>Bessie Kalin</u> ADDRESS <u>2502 Bellin Road Baltimore 21209</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Bronchopneumonia</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Chronic Pulmonary Fibrosis + Emphysema</u> <u>Old Pulmonary Tuberculosis</u> <u>40 yrs.</u> | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-19-1950</u> to <u>2-27-1967</u> , that (I) (we) last saw the deceased alive on <u>2-27-1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Joe Ardaiz</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>2-27-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Jose ARDAIZ</u> | | 23D. ADDRESS M.D. <u>5912 Cross Country Blvd. Baltimore, Md. 21215</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/1/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Beth Yehuda Ankle Kurland</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 6 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Seligman</u> | |
| 25C. FUNERAL DIRECTOR <u>Sol Levinson & Sons Inc., Balt. Md.</u> | | 25D. ADDRESS <u>6010</u> | | | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2149 | |
|---|-------------------------|--|------------------------------------|--|--|
| BIRTH NO. 67 2149 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>R. AITZYK, SEFFREY</u> | | 2. DATE AND HOUR OF DEATH <u>2/28/67</u> <u>1</u> <u>4</u> ¹⁰ <u>A.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>BALTIMORE CITY HOSPITALS</u> <u>4940 EASTERN AVENUE</u> <u>BALTIMORE, MARYLAND #21224</u> | | A. STATE <u>MARYLAND</u> B. COUNTY <u>Balt Co.</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>53-00</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>6631 DALTON DRIVE</u> <u>#21207</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u> | 8. DATE OF BIRTH <u>12-6-53</u> | 9. AGE (In years last birthday) <u>13</u> | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>School</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>MURRAY I. RAITZYK</u> | | 14. MOTHER'S MAIDEN NAME <u>GILDA WYMAN</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>No</u> | | 17. INFORMANT <u>#21224</u> <u>RECORDS-BCH-4940 EASTERN AVENUE-BALTIMORE, MD</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>340.13</u> | | CAUSE OF DEATH (A) <u>cerebral edema + status epilepticus</u> (B) <u>chronic arachnoiditis prob 11 yrs</u> (C) <u>etiology not determined</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>Many - last</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>B</u> | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-23-</u> <u>19 67</u> to <u>2-28-</u> <u>19 67</u> , that (I) (we) lost saw the deceased alive on <u>2-28</u> <u>19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Phillip L. Hall</u> | | | | 23B. DATE SIGNED <u>2-28-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Phillip L. Hall</u> | | | | 23D. ADDRESS <u>#21224</u> <u>BCH-4940 EASTERN AVENUE-BALTIMORE, MD.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/1/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Beth Israel</u> | |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| 24G. DATE REC'D BY HEALTH DEPT. | | 24H. NAME OF REGISTRAR | | 24I. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reisterstown</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2150 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2150 | |
|--|--|--|--|--|--|--|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Rose J. Gross | | 2. DATE AND HOUR OF DEATH Feb. 27, 1967 8 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Levin Dale, Hebrew Home and Infirmary | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-17 | | | |
| D. STREET ADDRESS (If rural, give location) Belvidere at Greenspring Ave. | | | | 5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow | | | |
| 8. DATE OF BIRTH 4-24-87 9. AGE (In years last birthday) 79 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 11. BIRTHPLACE (State or foreign country) Russia 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Samuel Cooper 14. MOTHER'S MAIDEN NAME Hannah ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. UNKNOWN 17. INFORMANT Mrs. Beatrice Miller ADDRESS Baltimore 15908 Gross Country Blvd | | | | 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia extensive INTERVAL BETWEEN ONSET AND DEATH 10 days | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. severe Kyphosis, Emphysema | | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? | | | | 22. I certify that (I) (this hospital) attended the deceased from Dec. 18 1962 to Feb. 27 1967 , that (I) (we) last saw the deceased alive on Feb. 27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Ruth Willner M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> 23B. DATE SIGNED 2.27.67 | | | | 23C. PHYSICIAN'S NAME (Type) Ruth Willner M.D. 23D. ADDRESS Levin Dale Hebrew Home and Infirmary | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE Feb 28/67 24C. NAME OF CEMETERY or CREMATORY Baltimore Hebrew 24D. LOCATION (City, town, or county) (State) Baltimore, Md | | | | 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 25B. NAME OF REGISTRAR Robert E. Fickens 25C. FUNERAL DIRECTOR Samuel E. Fickens ADDRESS 200 - 6010 Reisterstown Rd | | | |

Mr. Eastman
Baltimore
Baltimore at Washington Ave.
4-24-43

Passion
USA
Hawaii
Mrs. Beatrice Miller

F
W
W
Hawaii
Samuel Cooper

NO 08

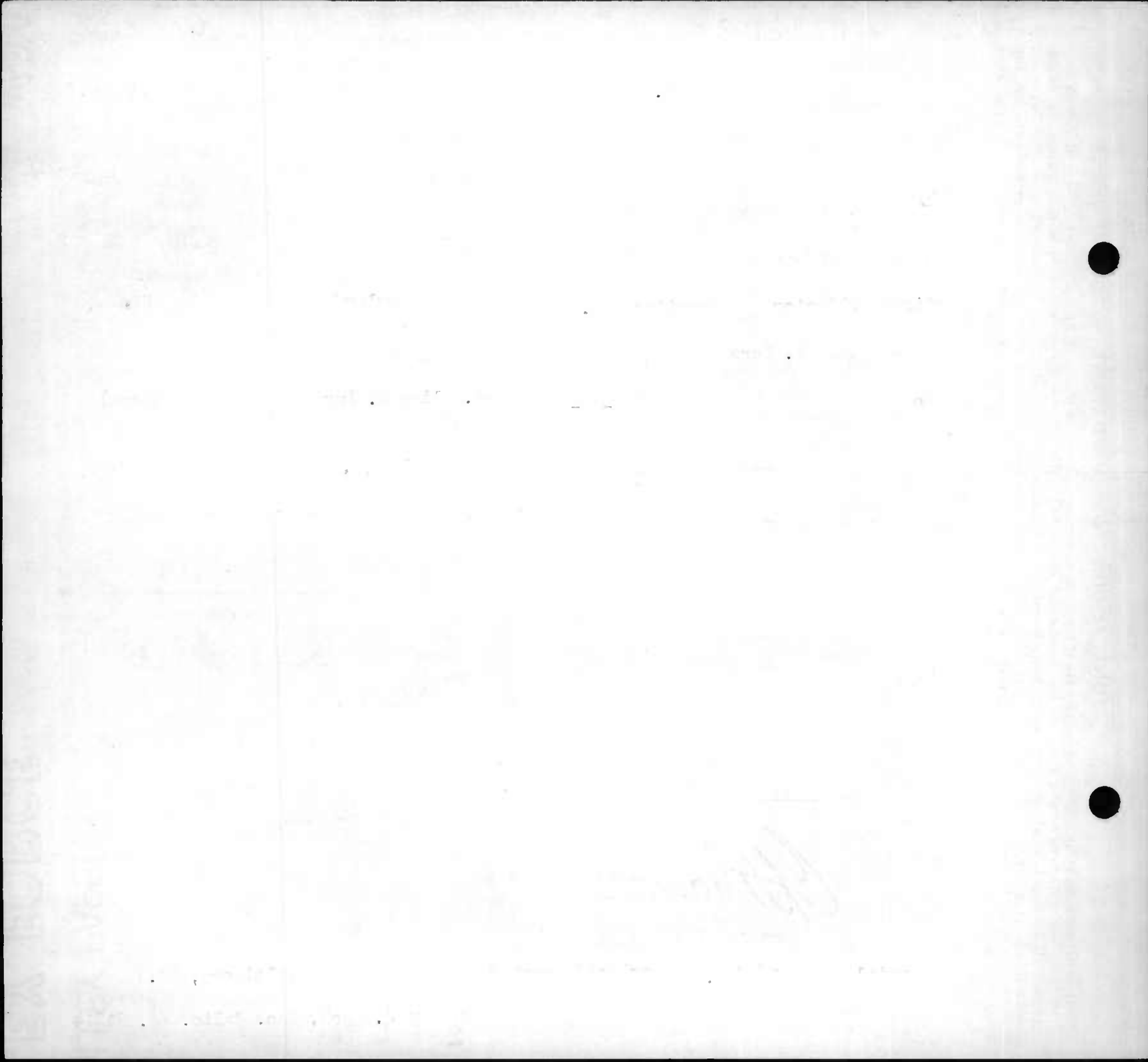
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2151 | |
|--|-----------------------------|---|---|--|---|
| BIRTH NO. 67 2151 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Casper M. Bayer | | | 2. DATE AND HOUR OF DEATH 3-2-67 9:50 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 21214 D. STREET ADDRESS (If rural, give location) 5135 Harford Rd | | |
| 5. SEX Male | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 11/18/99 | 9. AGE (In years last birthday) 68 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tailor |
| 11. BIRTHPLACE (State or foreign country) Baltimore Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME George Bayer | | | 14. MOTHER'S MAIDEN NAME Theresa Schuch | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 213-09-548 | | |
| 17. INFORMANT Mrs. Catherine Reuschling (Same) | | | ADDRESS | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 00341 | | | CAUSE OF DEATH (A) Congestive Heart Failure (B) Septicemia (C) Arteriosclerosis | | |
| 19. DATE OF OPERATION 0 | | | 20. AUTOPSY? (Yes or No) No | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-1 19 67 to 3-2 19 67 , that (I) was lost saw the deceased alive on 3-2 19 67 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE Ralph M. Howard | | | 23B. DATE SIGNED 3-2-67 | | |
| 23C. PHYSICIAN'S NAME (Type) Ralph M. Howard | | | 23D. ADDRESS M.D. University Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/6/67 | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR Ralph E. Taylor | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|-------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2152 | |
| BIRTH NO. 67 2152 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 3/3/67 15:14 a. M. | |
| 1. NAME OF DECEASED (Type or Print) Lurz, Raymond J. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21206 26-01 D. STREET ADDRESS (If rural, give location) 4504 Mary Avenue | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 3/20/89 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Collector | | 10B. KIND OF BUSINESS OR INDUSTRY Furniture Co. | 9. AGE (In years lost birthday) 77 |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joseph A. Lurz | | 14. MOTHER'S MAIDEN NAME - ? Fitzgerald | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-09-4644 | 17. INFORMANT Mrs. Alice C. Lurz |
| 18. 4-20-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized arteriosclerosis ANTECEDENT CAUSES Acute myocardial infarction DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 8 hrs. | | CAUSE OF DEATH (A) Generalized arteriosclerosis DUE TO (B) Acute myocardial infarction DUE TO (C) | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 6 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/2/67 to 3/3/67 19 67 that (I) (we) last saw the deceased alive on 3/3/67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE C.H. Brown, III | | 23B. DATE SIGNED 3/3/67 | |
| 23C. PHYSICIAN'S NAME (Type) C.H. Brown, III | | 23D. ADDRESS Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/6/67 | |
| 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Leonard J. Ryck, Inc. Balto. Md. 21214 | | ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|---|------------------------------------|---|---|
| B-16 31 66-19244 67 2153 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2153 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) ELEANOR JEAN BARDFELD | | | | 3/2/67 1:50 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital | | | | A. STATE MD. B. COUNTY BALTIMORE | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 26-34 | |
| D. STREET ADDRESS (If rural, give location) 5425 A SARRIL RD. | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH 9/12/66 | 9. AGE (In years lost birthday) 5 mon | If Under 1 Yr. Months Days 5 18 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | |
| 13. FATHER'S NAME PHILIP BARDFELD | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 14. MOTHER'S MAIDEN NAME ANDREA HOFFMAN | |
| 16. SOCIAL SECURITY NO. No | | | | 17. INFORMANT ADDRESS FATHER, DR. PHILIP BARDFELD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 2573 | | | | CAUSE OF DEATH (A) SUDDEN UNEXPECTED, UNEXP. INFANT DEATH (B) CARDIO-RESPIR. ARREST. (C) | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hr 5 min 1 hr 5 min | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | TURNER'S SYNDR. | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MAR 2 19 67 to MAR 2 19 67 , that (I) (we) last saw the deceased alive on Never DOA 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard W. Dodds M.D. | | | | 23B. DATE SIGNED 3/2/67 | |
| 23C. PHYSICIAN'S NAME (Type) RICHARD W. DODDS | | | | 23D. ADDRESS JOHNS HOPKINS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION | | 24B. DATE 3/3/67 | | 24C. NAME OF CEMETERY OR CREMATORY London Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | |
| 25B. NAME OF REGISTRAR Phyllis E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros Inc 6010 Reisterstown Rd | | | |

THE
FEDERAL
BUREAU OF
INVESTIGATION
UNITED STATES DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR

SUBJECT: [Illegible]

DATE: [Illegible]

BY: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

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65. [Illegible]

66. [Illegible]

67. [Illegible]

68. [Illegible]

69. [Illegible]

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71. [Illegible]

72. [Illegible]

73. [Illegible]

74. [Illegible]

75. [Illegible]

76. [Illegible]

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78. [Illegible]

79. [Illegible]

80. [Illegible]

81. [Illegible]

82. [Illegible]

83. [Illegible]

84. [Illegible]

85. [Illegible]

86. [Illegible]

87. [Illegible]

88. [Illegible]

89. [Illegible]

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91. [Illegible]

92. [Illegible]

93. [Illegible]

94. [Illegible]

95. [Illegible]

96. [Illegible]

97. [Illegible]

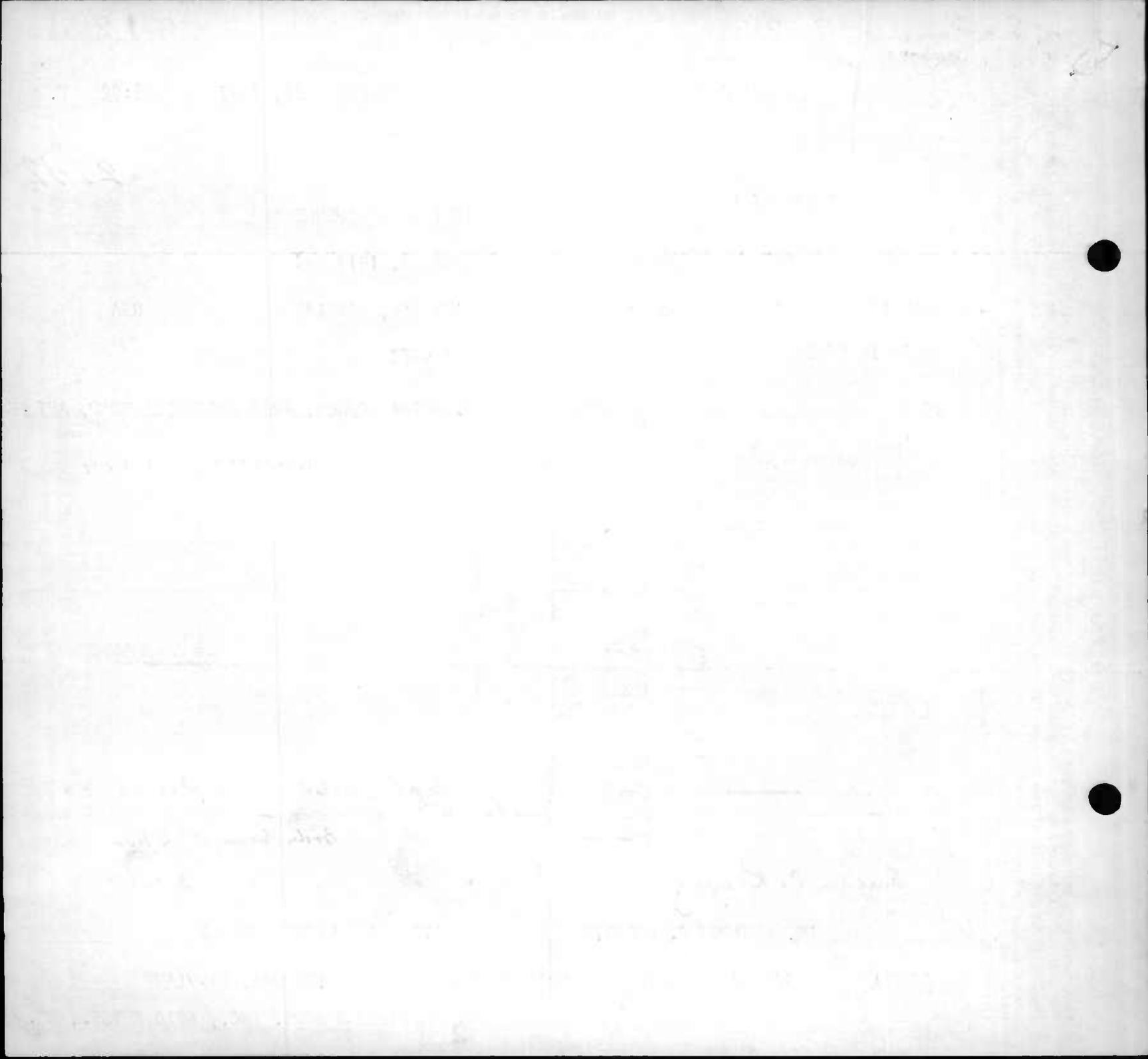
98. [Illegible]

99. [Illegible]

100. [Illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2154</u> | |
|---|----------------------|---|---|--|--|
| BIRTH NO. <u>67 2154</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH <u>FEBRUARY 28, 1967</u> <u>9:02</u> P. M. | | | |
| 1. NAME OF DECEASED (Type or Print) <u>IDA COHEN</u> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2701 UHLER AVENUE</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>SINGLE</u> | 8. DATE OF BIRTH <u>February 3, 1913</u> | 9. AGE (In years last birthday) <u>54</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESLADY</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>BENJAMIN COHEN</u> | | 14. MOTHER'S MAIDEN NAME <u>ANNA KATZ</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | | 17. INFORMANT ADDRESS <u>MR. NATHAN COHEN, 6958 BROOKMILL ROAD, APT 2 B</u> | |
| 18. <u>420.11</u> CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute myocardial infarction</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 19 67</u> to <u>Feb 28 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 20 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. <u>Body brought to Sinai Hospital.</u> | | | | | |
| 23A. SIGNATURE <u>Sheldon C. Kravitz</u> M.D. | | | | 23B. DATE SIGNED <u>3-1-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. SHELDON C. KRAVITZ</u> M.D. | | | | 23D. ADDRESS <u>6715 PARK HEIGHTS AVENUE</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3/2/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>BETH HAMEDROSH HAGODOL</u> | |
| 24D. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u> | | 24E. (State) | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. <u>MAR 6 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</u> | |



BIRTH NO.

67 2155

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2155

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Henry Kellman

2. DATE AND HOUR PRONOUNCED DEAD

3/1/67 11:00 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

42

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3915 Norfolk Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

February 26, 1905

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Merchant

10B. KIND OF BUSINESS OR INDUSTRY

Wholesale Fish

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Aaron I. Kellman

14. MOTHER'S MAIDEN NAME

Rica H. Rosenstein

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

214-03-0565

17. INFORMANT

ADDRESS

Mrs. Lydia Berman, 3628 Coronado Road #7

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic cardiovascular disease
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

3/2/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/3/67

23C. NAME of CEMETERY or CREMATORY

Bnai Israel

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 6

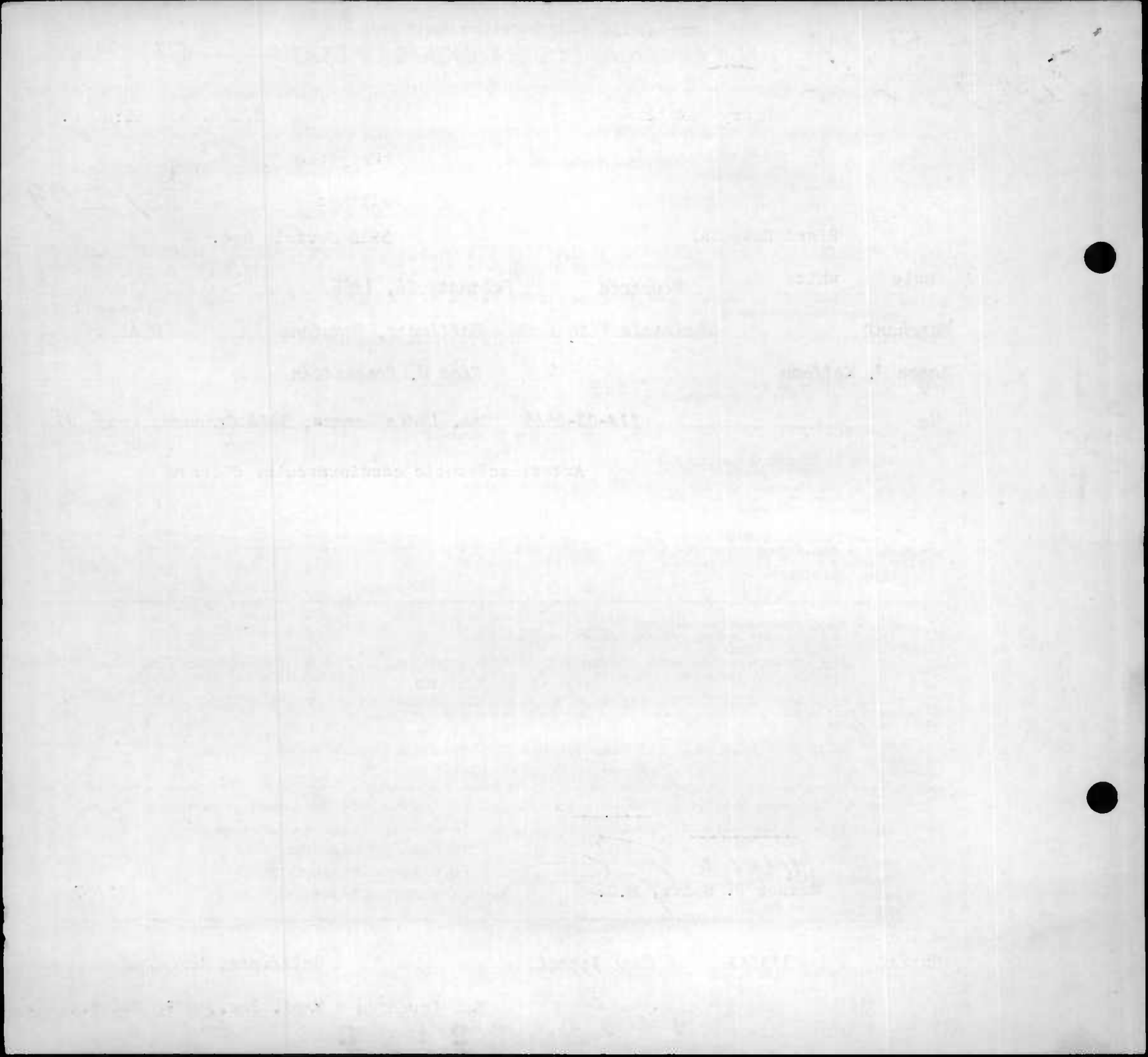
1967

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Sol Levinson & Bros. Inc., 6010 Reist., Rd.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| BIRTH NO. 67 2156 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 2156 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) EDITH CROWL | | | |
| 2. DATE AND HOUR OF DEATH 3/1/67 10:15 P.M. | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 md Gen. Hosp. Balto., md. | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE MARYLAND B. COUNTY Harford Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) "STREET" D. STREET ADDRESS (If rural, give location) Grier Nursery Road | | | | 5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | | |
| 8. DATE OF BIRTH 6/14/92 9. AGE (In years last birthday) 74 | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | |
| 11. BIRTHPLACE (State or foreign country) FALLSTON, md. | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME JOHN IRWIN | | | | 14. MOTHER'S MAIDEN NAME MARY RILEY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 213-38-5583 | | 17. INFORMANT Charles A. Crowl ADDRESS Street, Maryland | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) septicemia INTERVAL BETWEEN ONSET AND DEATH 48 hr | | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. perforated bowel (? colon) 48 hr. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASCD | | | | 15 yr. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/1 19 67 to 3/1 19 67 , that (I) (we) last saw the deceased alive on 3/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Kenneth R. Kaskinen M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | | 23B. DATE SIGNED 3/1/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS md Gen Hosp Balto. md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/4/1967 | | 24C. NAME OF CEMETERY or CREMATORY Highland | | 24D. LOCATION (City, town, or county) (State) Street, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR Robert E. Sarkey, M.D. | | 25C. FUNERAL DIRECTOR Charles E. Kurtz | | ADDRESS Jarrettsville, Md. | |

not for Mary
Baker, ind

F W MARRIED

NAME

JOHN TOWN

NO

"SWEET!"
MARRIED

ol/12 24

EASTON, ind. USA

MARY RIVER

Kenneth R. Korman, ind

2-1-1942

Prof. A. L. (L. L. L.)

ASCHD

21 21

21 07

21 11

21 11

Kenneth R. Korman

not for Mary Baker, ind

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2157 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2157 | |
|--|--|--|--|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ISAACS, NELLIE M | | | | 2. DATE AND HOUR OF DEATH 3-2-67 6:00AM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE 29, MD. | | | | A. STATE MD B. COUNTY Balt Co. #28 | | | |
| 5. SEX FEMALE | | | | 6. RACE CAUCASION | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | |
| 8. DATE OF BIRTH 02-24-93 | | | | 9. AGE (In years last birthday) 74 | | 10. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME JOHN H. DAUBERT (DEC'D) | | | | 14. MOTHER'S MAIDEN NAME IDA DAUBERT (DEC'D) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS #29 ST. AGNES RECORDS: WILKENS & CATON AVES. | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CENTRAL CORONARY Subarachnoid Hemorrhage 14. S.C. VD INTERVAL BETWEEN ONSET AND DEATH 50 days. | | | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 21. DATE OF OPERATION | | | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 23. AUTOPSY? (Yes or No) | |
| 24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 27. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 28. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 29. HOW DID INJURY OCCUR? | |
| 30. I certify that (I) (this hospital) attended the deceased from JANUARY 11 19 67 to MARCH 2 19 67, that (I) (we) lost saw the deceased alive on MARCH 2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 31. SIGNATURE Alejandro Mejia | | | | 32. DATE SIGNED March 2/67 | | 33. PHYSICIAN'S NAME (Type) ALEJANDRO MEJIA | |
| 34. ADDRESS WILKENS & CATON AVES. BALTO. 29, MD. | | | | 35. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | |
| 36. NAME OF CEMETERY or CREMATORY BALTO. NATIONAL | | | | 37. LOCATION BALTO. MD | | 38. FUNERAL DIRECTOR E.S. MALNAB | |
| 39. ADDRESS 301 FREDERICK RD | | | | 40. ADDRESS 21228 | | | |

1000

3

United States

Subsidiary Company

W.C. VD

Signature
Name

Page 2/2

P-620

67 2158

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2158

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSPHINE PIERCE

2. DATE AND HOUR PRONOUNCED DEAD

March 3, 1967 1:14 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1919 Rosedale Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1919 Rosedale Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

Aug. 9, 1934

9. AGE (In years
last birthday)

32

10. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Printer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

James Smallwood

14. MOTHER'S MARRIAGE NAME

Josephine Shannon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Josephine Smallwood - 1126 N. Fullerton Ave

18. E 904.9

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Subdural hematoma

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Unknown

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Unknown

00-00

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

Unknown

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Probably fell

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

March 3, 1967

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

3/3/67

23C. NAME OF CEMETERY or CREMATORY

Balto National

23D. LOCATION

Balto

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 6 1967

O. B. E. Jones

MRS A. H. W. JONES, JR. HARFORD AVE.

Received

from

for

of

to

FOR

and

into

of

of

of

1955

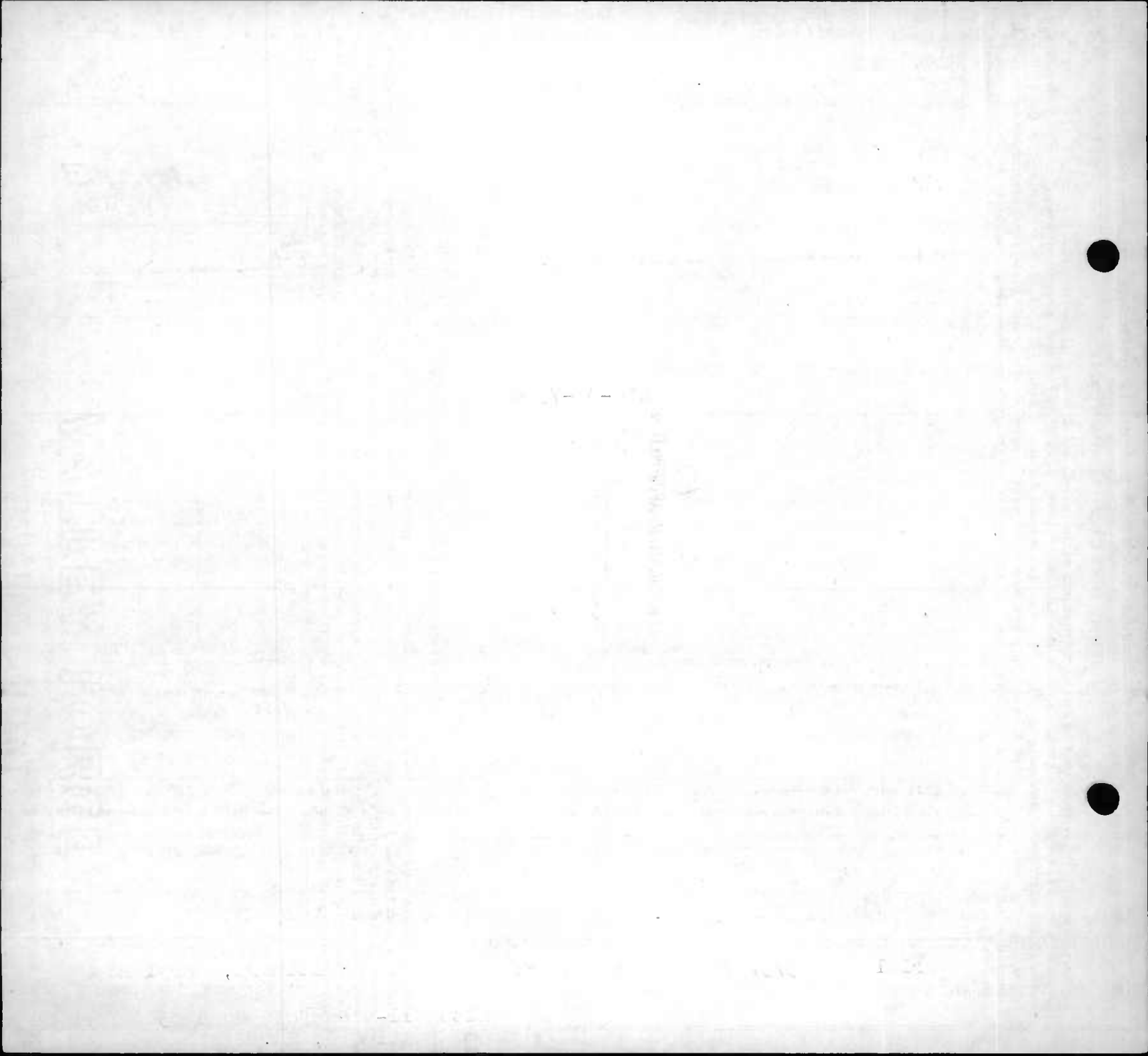
Received from

certificate to be approved by medical examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 67 2159 | | REGISTERED NO. 67 2159 | |
|---|---------------------|--|-----------------------------------|--|-----------------------------|---|------------------------------|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) MCCAULEY, RUTH E. | | | | 2. DATE AND HOUR OF DEATH 2.28.67 1 9:00 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BOLTON HILL CONVALESCENT HOME 90 LAFAYETTE & JOHN ST. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 14-03 | | | |
| D. STREET ADDRESS (If rural, give location) PARK HILL CONVALESCENT HOME | | | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 4.5.82 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER | | 10B. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 216-46-7598 | | 17. INFORMANT ADDRESS DECEASED | |
| <div style="writing-mode: vertical-rl; transform: rotate(180deg); position: absolute; left: 50%; top: 50%; font-weight: bold;"> CERTIFICATION APPROVED BY [Signature] CHIEF MEDICAL EXAMINER </div> | | | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH E903.7 BRONCHO PNEUMONIA | | INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| | | | | (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | |
| | | | | 18. ANTECEDENT CAUSES 2 | | | |
| | | | | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. II | | | | | | | |
| 19A. DATE OF OPERATION 1 2/2/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACT. LEFT HIP | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) PARK HILL CONVALESCENT HOME | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) PARK HILL CONVALESCENT HOME 14-03 | | | |
| 21D. TIME OF INJURY (Approx.) 2:30 PM - 1.29.67 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? FELL ON WAY TO BATHROOM | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7.24 1951 to 2.28 1967 , that (I) (we) last saw the deceased alive on 2.25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Paul G. Herold | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2.28.67 | |
| 23C. PHYSICIAN'S NAME (Type) PAUL G. HEROLD | | | | 23D. ADDRESS 10 W. MADISON ST | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/3/67 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home 6500 York Rd Baltimore, Md. 21212 | | | |



L-516

67 2160

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2160

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Flora L. Lambert

2. DATE AND HOUR PRONOUNCED DEAD

3/1/67 8:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

100 W. Cold Spring La.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
married

8. DATE OF BIRTH

3/5/1888

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

J. William Schaefer

14. MOTHER'S MAIDEN NAME

Mathilde Erck

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

213-12-0886

17. INFORMANT

ADDRESS

Jack L. Lambert 100 W. Coldspring Lane

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

3/1/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

23B. DATE

3/6/67

23C. NAME of CEMETERY or CREMATORY

Loudon Park

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 6 1967

24B. NAME OF REGISTRAR

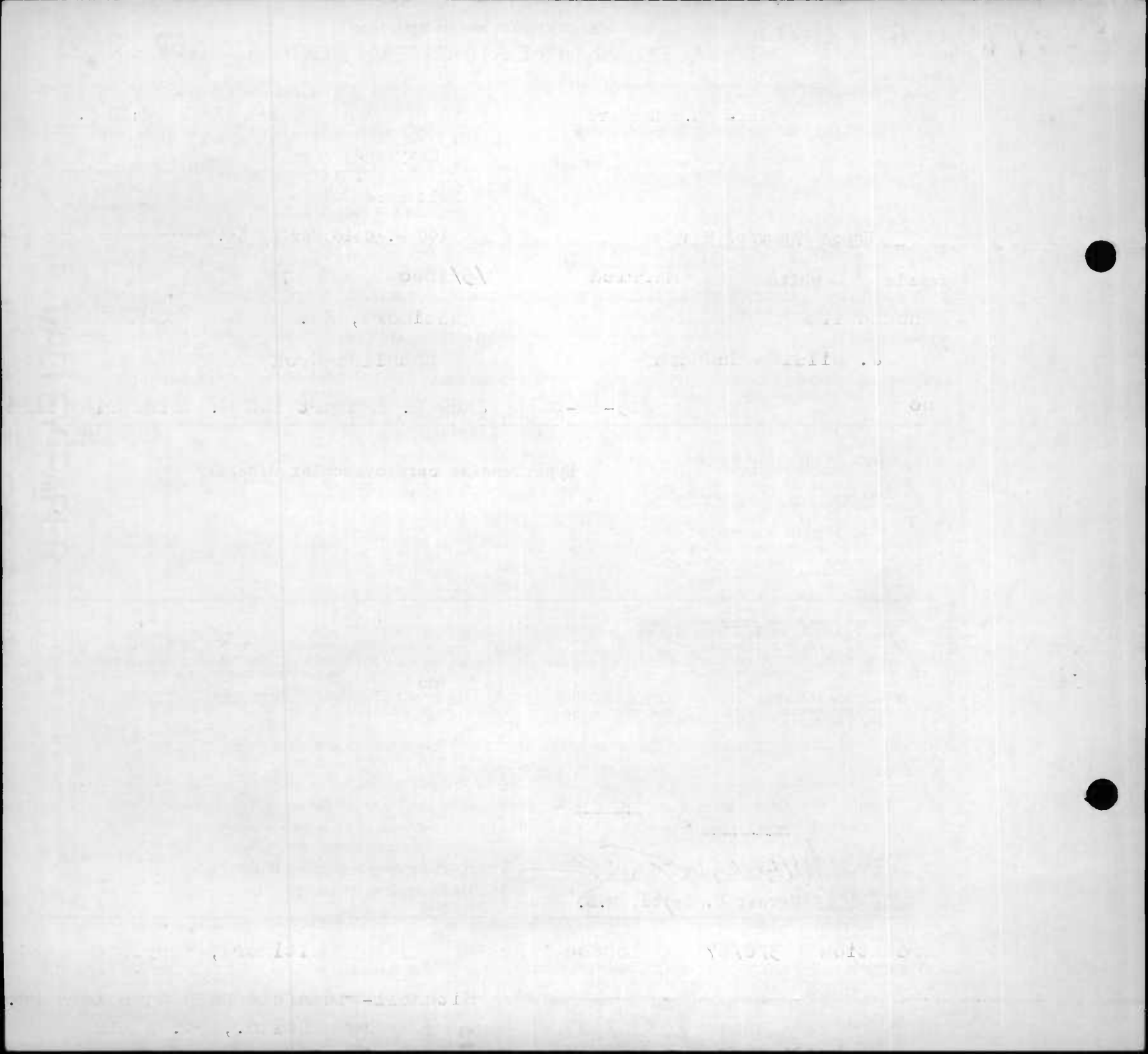
Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Mitchell-Wiedefeld Home 6500 York Rd.

Balto., Md. 21212



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|---------------------|--|--|--|--|--|---|--|---------------------------------|----------------------------------|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2161 | | | | | |
| BIRTH NO. 67 2161 | | | | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Mc Garvey, Francis James</u> | | | | | 2. DATE AND HOUR OF DEATH <u>9.20 Am. Mar. 1, 1967</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Union Memorial Hospital</u> | | | | | A. STATE <u>Md</u> B. COUNTY | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>3203 St. Paul St.</u> | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>M</u> | | 8. DATE OF BIRTH <u>05-16-09</u> | 9. AGE (In years last birthday) <u>57</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>American</u> | | |
| 13. FATHER'S NAME <u>Frank P. Mc Garvey</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Jenny Mc Nicholas</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES W.W. II</u> | | | | | 16. SOCIAL SECURITY NO. <u>215-09-1943</u> | | 17. INFORMANT <u>Catherine Mc Garvey</u> | | ADDRESS <u>Same</u> | |
| 18. <u>351.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Liver Cirrhosis & GI bleeding</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2:00 Am. Mar. 1, 1967</u> to <u>9:20 Am. Mar. 1, 1967</u> , that (I) (we) last saw the deceased alive on <u>9:20 Am. Mar. 1, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <u>Sang Won Song</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>March 1, 1967</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>SANG WON SONG</u> | | | | | 23D. ADDRESS M.D. <u>THE UNION MEMORIAL HOSPITAL</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/3/67</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Balto. National</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 6 1967</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Farber</u> | | | 25C. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home</u> | | | ADDRESS <u>6500 York Rd.</u> | |

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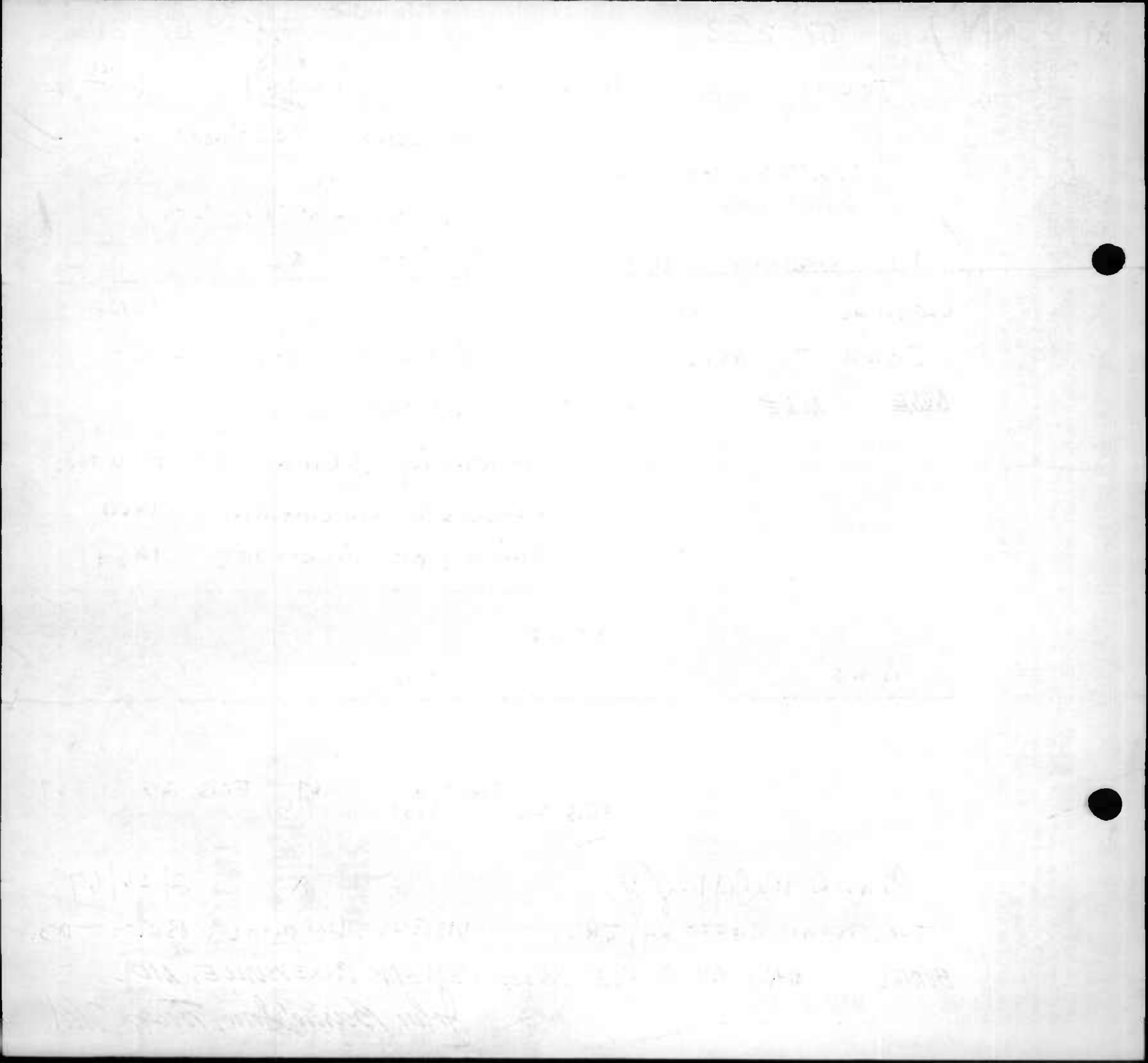
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-----------------------------|--|---|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2162 | | | | |
| BIRTH NO. 67 2162 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) JOHN EDWARD Mix | | | | | 2. DATE AND HOUR OF DEATH 2/26/67 6:40 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 28 USPHS Hospital BALTIMORE, MD. | | | | | A. STATE MARYLAND | | | | |
| | | | | | B. COUNTY BALTIMORE Co. | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Timonium 33-00 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 7 WASHINGTON ST. | | | | |
| 5. SEX M | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | | 8. DATE OF BIRTH 8/19/04 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIEF CLERK | | | 10B. KIND OF BUSINESS OR INDUSTRY Hardware Store | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOHN T. Mix | | | | | 14. MOTHER'S MAIDEN NAME PAULINE VONDERHEIT | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE | | | 16. SOCIAL SECURITY NO. 215 098811 | | 17. INFORMANT ADDRESS (PATIENT) | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) HEPATIC COMA | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 WEEK | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. METASTATIC CARCINOMA | | | | | 1964 | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CANCER OF BLADDER | | | | | 1964 | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE | | | | | | | | | |
| 19A. DATE OF OPERATION NONE | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JAN. 4 19 67 to FEB 26 19 67 , that (I) (we) last saw the deceased alive on FEB 26 19 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE John D. McCaffery Jr. | | | | | | | | 23B. DATE SIGNED 2/26/67 | |
| 23C. PHYSICIAN'S NAME (Type) THOS. D. McCAFFERY, JR. | | | | | | | | 23D. ADDRESS USPHS Hospital, BALT. MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE MAR. 1, 1967 | | 24C. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY MEM. GNS. COCKEYSVILLE, MD. | | 24D. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR John Burns' Sons, Towson, Md. | | ADDRESS | | | |



1
R-152

67 2163

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2163

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Harold J. Robinson

2. DATE AND HOUR PRONOUNCED DEAD

3/4/67 9:35 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1905 W. Lanvale St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

3/20/1935

9. AGE (In years
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

LEE ROBINSON

14. MOTHER'S MAIDEN NAME

Marjorie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

ANNIE KENNEDY 1115 McALEER CT.

18. E981X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO Multiple Gunshot Wounds.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

in front of 1530 Ashland Ave. 7-04

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)
3 4 67 8:55p

21E. INJURY OCCURRED

WHILE AT
WORK

NOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?
shot several times

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/5/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/8/67

23C. NAME OF CEMETERY or CREMATORY

MT. CALVARY Cem.

23D. LOCATION

(City, town, or county)

A.A. County

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 6 1967

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Milton E. Erickson

ADDRESS

1129

1
L-220

67 2164

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2164

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EDWARD J. LUKOWSKI

2. DATE AND HOUR PRONOUNCED DEAD

March 3, 1967 7:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home & Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1718 Thames Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Oct. 3, 1898

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Tavern Owner

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Peter Lukowski

14. MOTHER'S MAIDEN NAME

Bogumita

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-14-1140

17. INFORMANT

ADDRESS

Mrs. Veronica Lukowski 1718 Thames Street

18. 420.01

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK

NOT WHILE
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion

resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

Charles S. Springate

M.D.

ASSISTANT MEDICAL EXAMINER ☒

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

ASSOCIATE MEDICAL EXAMINER ☐

March 3, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-7-1967

23C. NAME of CEMETERY or CREMATORY

Holy Rosary

23D. LOCATION

(City, town, or county)

(State)

Baltimore County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 6

1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

ADDRESS

Lilly & Zeiler Inc.

1901-07 Eastern Ave.

VIA
AIR MAIL
POSTAGE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| P-623 | | 67 2165 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 67 2165 | |
|--|---------|--|--|---|------------------------------------|---|--|---|--|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| | | | | PRESTON, ERNEST OSGOOD | | 3 MARCH 67 1 8:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | | | |
| | | UNION MEMORIAL Hosp. 44 | | Md. BALTIMORE Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Rogers Forge 53-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | 6819 BLENHEIM ROAD | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | |
| M | W | MARRIED | | 05-13-88 | 78 | Retired | | USA | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| | | Salesman | | Md. | | USA | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| ERNEST O. PRESTON | | AM ELIA Stamp | | No None | | CNone | | Mr. Charles W. Preston 3612 Stoneybrook Rd. | |
| 18. 03341 | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | CHF (Congestive Heart Failure) | | | |
| | | ANTECEDENT CAUSES | | (B) DUE TO | | ARCUD | | | |
| | | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | Septicemia | | McGraw | |
| | | II | | | | | | | |
| | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 2 | | | | Yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | | | | | | | | |
| 22. I certify that (this hospital) attended the deceased from 1 MARCH 1967 to 3 MARCH 1967, that (we) last saw the deceased alive on 3 MARCH 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE | | 23B. DATE SIGNED | | | | | |
| | | Sidney E. Kirkley M.D. | | 3 March 67 | | | | | |
| 23C. PHYSICIAN'S NAME (Print) | | 23D. ADDRESS | | 23E. FUNERAL DIRECTOR | | 23F. ADDRESS | | | |
| Dr. Sidney E. Kirkley | | The Union Memorial Hospital | | Wm. J. Tuckman & Sons | | Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 3/7/1967 | | Woodlawn Cemetery | | Woodlawn, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | | |
| MAR 6 1967 | | R. E. E. E. E. | | Wm. J. Tuckman & Sons | | Baltimore, Md. | | | |

RECEIVED 10/10/10

PAID 10/10/10

UNION WORKERS

819 BIRCHMOUNT ROAD

02-13-10

M W MARKED

124

MD

10/10/10

AM 8:10

0.96222

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

10/10/10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|-------------------------|--|--|--|---|
| 67 2166 | | BALTIMORE CITY HEALTH DEPARTMENT | | 67 2166 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>LIPSON, CLARENCE ROBERT</u> | | | 2. DATE AND HOUR OF DEATH <u>Mar 4 '67</u> <u>10:35 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> | | | A. STATE <u>MARYLAND</u> B. COUNTY | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | |
| | | | D. STREET ADDRESS (If rural, give location) <u>318 BIRKWOOD</u> Place | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>06-09-1896</u> | 9. AGE (In years last birthday) <u>70</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) <u>GOVERNMENT EMP.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>GOVERNMENT EMP.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | |
| 13. FATHER'S NAME <u>HARRY LIPSON</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | | 16. SOCIAL SECURITY NO. | | |
| | | | 17. INFORMANT ADDRESS <u>Mrs. Ethel Lipson same address as above</u> | | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <u>Rupture of Heart</u> DUE TO (B) <u>Acute Myocardial Infarction</u> DUE TO (C) <u>Myocardial</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-2</u> 19 <u>67</u> to <u>3-4</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-4</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Fred J. Blomsson</u> | | | | 23B. DATE SIGNED <u>3-4 '67</u> | |
| 23C. PHYSICIAN'S NAME (Type or Print) <u>Fred J. Blomsson</u> | | | | 23D. ADDRESS <u>The Union Memorial Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/7/1967</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>Wm. J. Johnson & Son with H. A. Jones</u> | | | |

4

Frank 2. [unclear]
[unclear] [unclear] [unclear]
[unclear] [unclear] [unclear]

ACT 1

ACT 2

M-600

67 2167

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2167

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|---|----------------------------------|--|---|
| BIRTH NO. 67 2167 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2167 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MAYER, ERWIN EMANUEL | | 2. DATE AND HOUR OF DEATH 3 MARCH 67 4:50 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP. 44 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE City C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 320 KERNEWAY 21212 | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 06-21-98 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months: Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEDICAL DOCTOR | | 10B. KIND OF BUSINESS OR INDUSTRY PRIVATE PRACTICE | | 11. BIRTHPLACE (State or foreign country) GERMANY | |
| 13. FATHER'S NAME DR. A. H. MAYER | | 14. MOTHER'S MAIDEN NAME Ida Schnadig | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Evelyn Mayer same address as above | |
| 18. 4:50 P M DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. XSCVD | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 20 January | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 22 Feb 19 67 to 3 March 19 67 , that (H) (we) last saw the deceased alive on 3 MARCH 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sidney E. Kirkley | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3 March 67 | |
| 23C. PHYSICIAN'S NAME (Type) SIDNEY E. KIRKLEY | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 3/6/1967 | | 24C. NAME of CEMETERY or CREMATORY Greenmount Crematory | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | |
| 25B. NAME OF REGISTRAR Wm. J. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS Baltimore, Md. | | | |

DR. A. H. WATKINS

BRIDGE DOCTOR PRIVATE PRACTICE, BIRMINGHAM

DR. W. W. WATKINS

CE-21-28 25

350 KERRWAY

BIRMINGHAM

UNION MEMBERS

Good Morning
Yours

4-2

Robert E. K...
2100 E. 11th St.

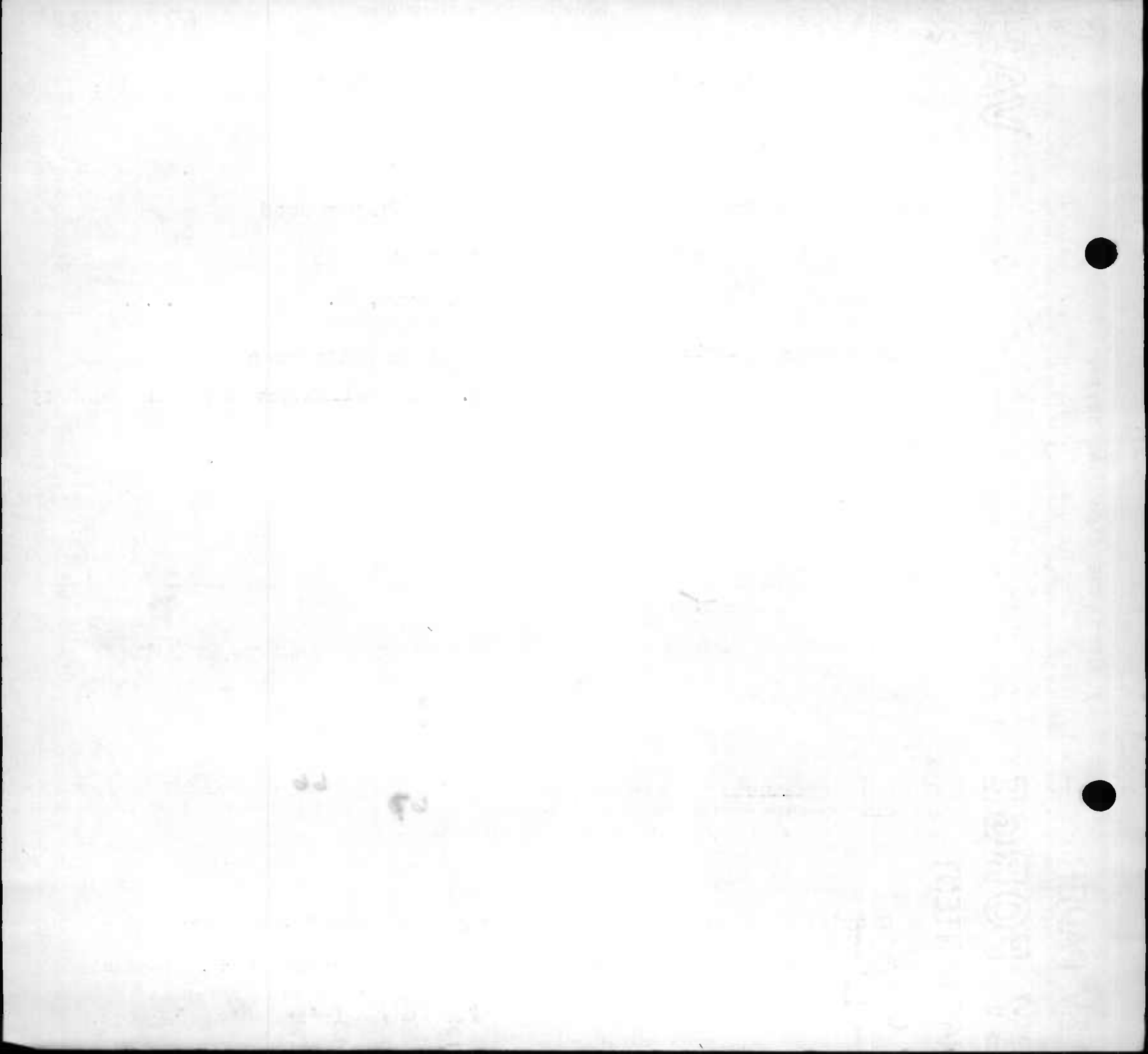
2100 E. 11th St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 2168 | |
|--|---------|--|-----------------------------------|---|---|--|------------------------------|
| BIRTH NO. 63-34346 | | 2168 | | DATE AND HOUR OF DEATH | | 3/3/67 11:45 A.M. | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | | |
| | | | | Laurie Lavin | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital | | | | A. STATE Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 447 Random Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. |
| Female | White | Child | 12/13/63 | 3 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| None | | | | | Baltimore, Md. | | U.S.A. |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Gregory Lavin | | | | Linda Balladarsch | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| | | | None | | Mr. Ernest Balladarsch 447 Random Road 29 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Anoxemia | | 60 hours | |
| ANTECEDENT CAUSES | | | | (B) Excessive secretions | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) Cryptic fibrosis | | 3 1/2 years | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | No. | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 19 66 to 3/3/67 that (I) (we) last saw the deceased alive on 3 March 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Charles Morehead | | | | 3 March 67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Charles Morehead | | | | The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 3/6/67 | | Lake View Cemetery | | Carroll County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| MAR 6 1967 | | Robert E. Farkas | | Wm. J. Dickner & Sons, North & Penna. Ave | | | |

1 9 6 7 0 0 0 2 1 7 5



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2169 | |
|---|---------|--|------------------|---|---|
| BIRTH NO. 67 2169 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | HUBER, PAUL H. | | MARCH 4, 1967 8:20 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| ST. AGNES HOSPITAL | | A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 WILKENS & CATON AVES. BALTO., MD. 21229 | | MARYLAND | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE 21229 25-41 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 3710 Clarenell Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| MALE | WHITE | WIDOWED | 09-29-97 | 69 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RETIRED | | Pattern Maker Bethlehem Steel Co. | | MARYLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| GEORGE W. Huber | | | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | 215055254 | | WILKENS & CATON AVES. ST. AGNES RECORD-BALTIMORE, MD. 21229 | |
| 18. 4221 I | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) St. Cerebellar Hemorrhage and subarachnoid hemorrhage | | | |
| ANTECEDENT CAUSES | | (B) ASCVD. | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MARCH 4, 1967</u> to <u>MARCH 4, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>MARCH 4, 1967</u> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) <u>J. B. HERTS, M.D. E. H. Weiss, M.D.</u> | | | | 23D. ADDRESS <u>WILKENS & CATON AVES. ST. AGNES HOSPITAL-BALTIMORE, MD. 21229</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3/7/1967 | | Lorraine Park Cemetery | |
| | | | | Woodlawn, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAR 6 1967 | | Robert E. [Signature] | | Wm. J. [Signature] | |

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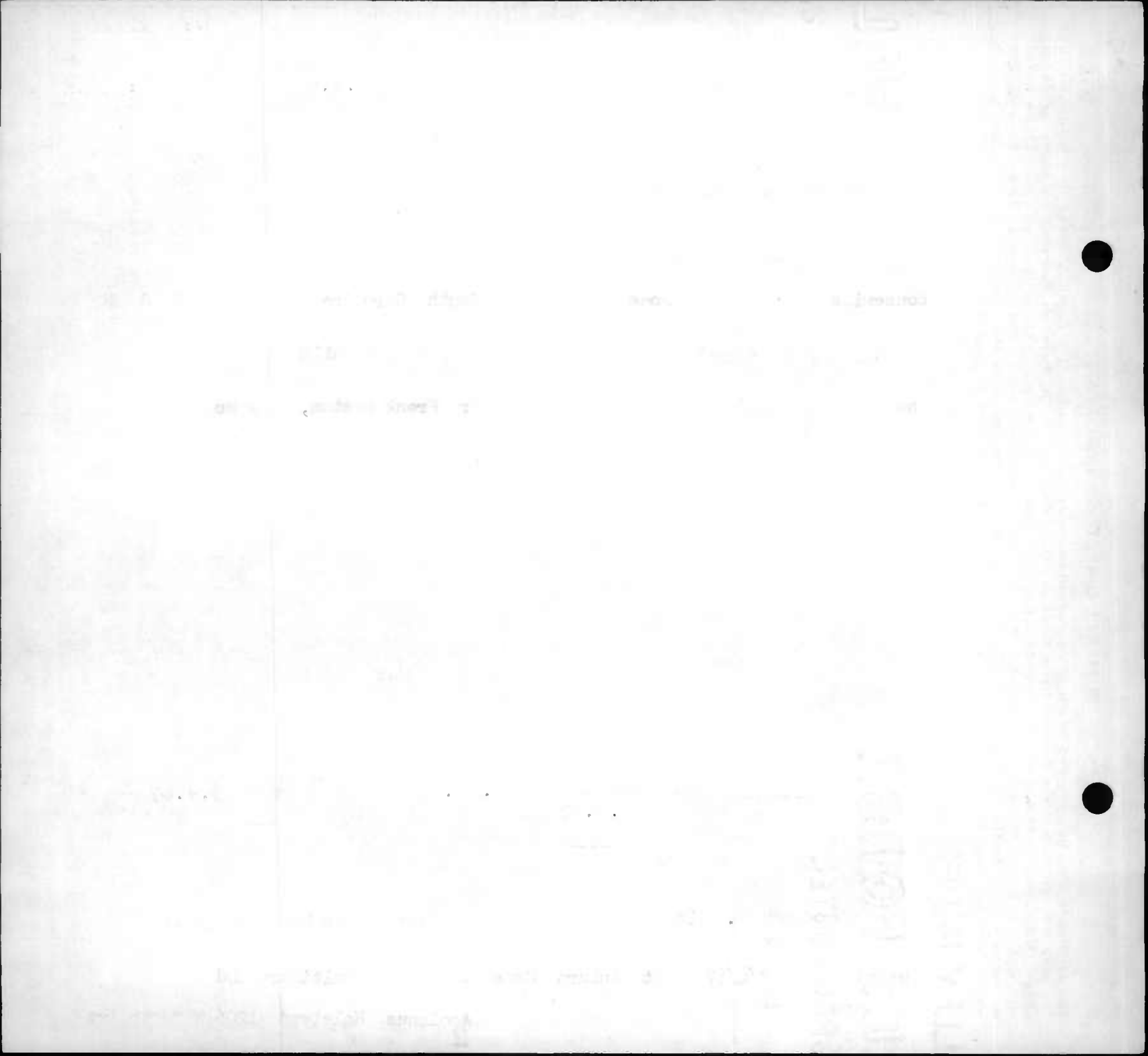
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

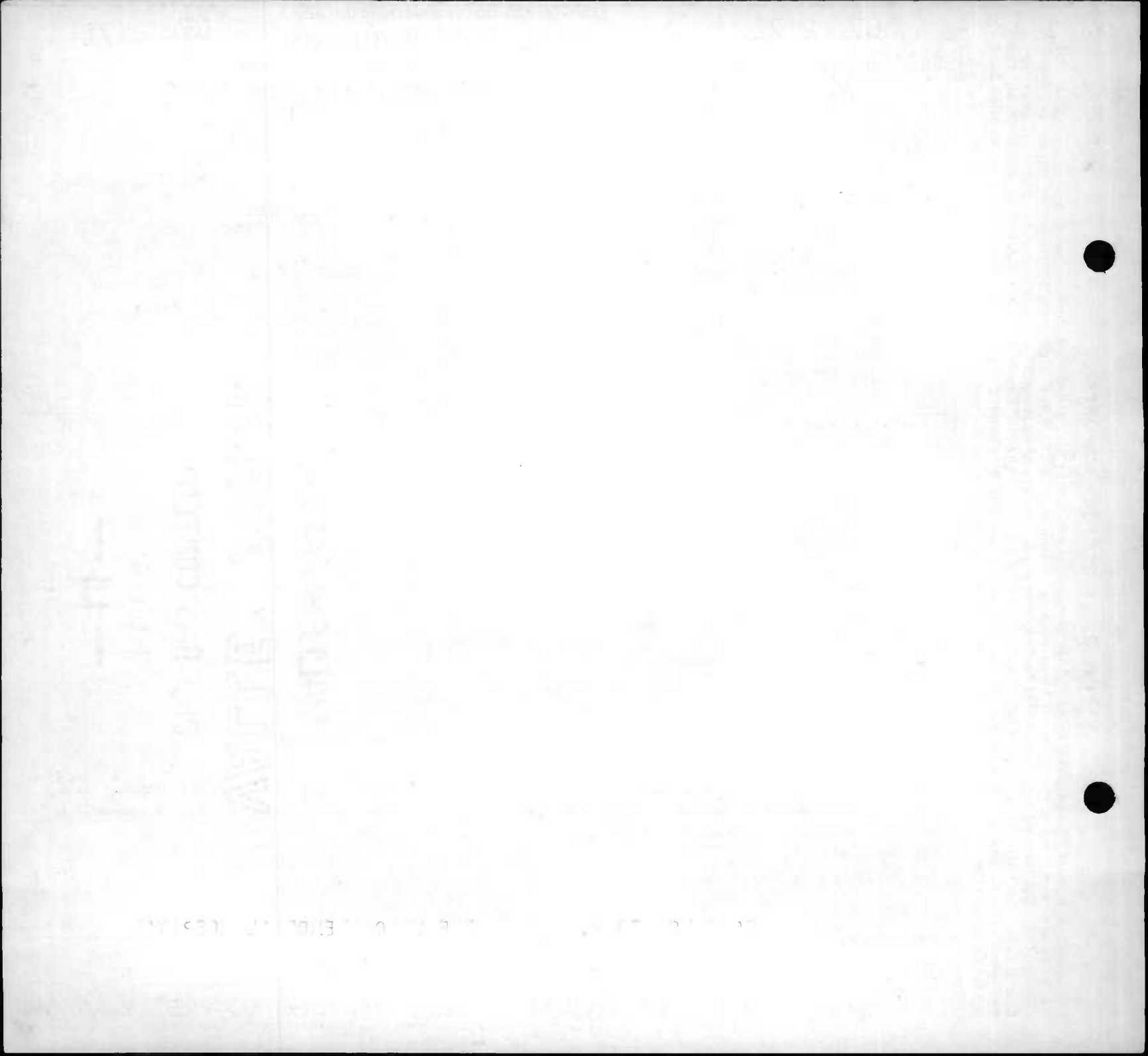
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2170 | |
|---|-------------------------|---|-----------------------------------|--|--|
| BIRTH NO. 67 2170 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Delia Weston | | | |
| 2. DATE AND HOUR OF DEATH 3.4.67 | | 8:55 AM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital 33 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 850 Abbott Court | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 5/ /05 | 9. AGE (In years last birthday) 61 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME George McDainel | | 14. MOTHER'S MAIDEN NAME Elvira Goodin | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mr Frank Weston, same | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CVA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Essential Hypertension | | INTERVAL BETWEEN ONSET AND DEATH 5 days 5 years | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2.27.67 19 to 3.4.67 19, that (I) (we) last saw the deceased alive on 3.4.67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R.M. Winslow | | | | 23B. DATE SIGNED 3/4/67 | |
| 23C. PHYSICIAN'S NAME (Type) Robert M. winslow | | | | 23D. ADDRESS Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/67 | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetr | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md | | 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2171 | |
|--|-------------------------|--|--|--|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 2171 CERTIFICATE OF DEATH </div> | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) Mason, Laymentress NMTN (MORAGANE) | | | 2. DATE AND HOUR OF DEATH 11.15 pm Mar. 2, 1967 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 12-04 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Union Memorial Hospital | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 2008 E. Barclay St. | | |
| 5. SEX F | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 02-16-22 | 9. AGE (In years last birthday) 45 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) N. Carolina | | 12. CITIZEN OF WHAT COUNTRY? American |
| 13. FATHER'S NAME Richard Godson | | | 14. MOTHER'S MAIDEN NAME Carrie Reel | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Frank Morogane 2008 E. Barclay St. |
| 18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cerebrovascular Accident | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3.25 pm. Mar 1 1967 to 11.15 pm Mar 2 1967 , that (I) (we) lost saw the deceased alive on 11.15 pm Mar. 2 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sang Won Song | | | | 23B. DATE SIGNED March 2, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/7/67 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn | |
| 24D. LOCATION Baltimore Md. | | 24E. NAME OF REGISTRAR Robert E. Taylor | | 24F. FUNERAL DIRECTOR WM MARCH 928 E North Ave | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |



BIRTH NO.

67 2172

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Ellam Johnson (or)
JOHNSON ELLAM

2. DATE AND HOUR PRONOUNCED DEAD

March 3, 1967

11:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)37
99 Mercy Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

425 Pittman Place

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

3-8-05

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Presser

10B. KIND OF BUSINESS OR INDUSTRY

Public

11. BIRTHPLACE (State or foreign country)

Chase City, Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Johnson Ellam

14. MOTHER'S MAIDEN NAME

Lindy Pettus

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W.W. #2

16. SOCIAL
SECURITY NO.

220-03-5601

17. INFORMANT

Pearl Ellam 425 Pittman Place

ADDRESS

18. 420.01

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A)
DUE TO

Arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m. WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Notogol causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 4, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-8-67

23C. NAME of CEMETERY or CREMATORY

National Cemetery

23D. LOCATION

Baltimore,

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 6 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Randolph J. Collick 2431 E. Oliver St.

ADDRESS

WILLIE FORGE

Johnson Ellen
yes W.W.S.

Class City, St.
Lindy Peters

3-8-68

3-8-68

3-8-68

Handwritten notes at bottom left.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| 48-76-85 E 1521 | | BALTIMORE CITY HEALTH DEPARTMENT | | 67 2173 | |
|--|------------------|--|--------------------------------|--|---|
| BIRTH NO. | | 67 2173 | | Registered No. | |
| M.E. CASE NO. | | 67 2173 | | 67 2173 | |
| 1. NAME OF DECEASED (Type or Print) | | EVANS, LAWRENCE R. | | 2. DATE AND HOUR OF DEATH MARCH 3, 1967 1 630 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE Maryland | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | B. COUNTY 8-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | D. STREET ADDRESS (If rural, give location) 2628 Beryl Avenue 21205 | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 10-15-1928 | 9. AGE (In years last birthday) 38 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | | 10B. KIND OF BUSINESS OR INDUSTRY GOVERNMENT | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Willie EVANS | | 14. MOTHER'S MAIDEN NAME Pauline Randolph | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W.#2 | | 16. SOCIAL SECURITY NO. 216-14-4693 | | 17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (A) DUE TO Septicemia (B) DUE TO Acute Leukemia (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 4 days 3 1/2 months | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from Feb. 24 1967 to Mar 3 1967, that (1) (we) lost saw the deceased alive on Mar 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Dr. Alexander Silverman | | 23B. DATE SIGNED Mar 3, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Alexander Silverman | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-7-67 | | 24C. NAME OF CEMETERY or CREMATORY National Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR Robert E. Jackson | |
| 25C. FUNERAL DIRECTOR Collick | | 25D. ADDRESS 2431 E. Oliver St. | | | |

GOVERNMENT

REVENUE

DEPARTMENT

REVENUE

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REVENUE

M. 235

67 2174

BALTIMORE CITY HEALTH DEPARTMENT

67 2174

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

| | | | | | | | |
|--|---------------------------|--|--|--|--|---|---|
| 1. NAME OF DECEASED (Type or Print) Laura McDonald | | | | 2. DATE AND HOUR PRONOUNCED DEAD 3/4/67 11:05 a. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 841 Fairmount Ave. | | | |
| 5. SEX female | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 3/29/01904 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Williams | | | | 14. MOTHER'S MAIDEN NAME Annie | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Henry McDonald 841 W. Fairmount Ave | | |
| 18. CAUSE OF DEATH 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary emphysema | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/5/67 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 3/9/67 | | 23C. NAME of CEMETERY or CREMATORY Carver Memorial Pk. | | 23D. LOCATION (City, town, or county) (State) Laurel Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | 24B. NAME OF REGISTRAR Robert E. Taylor | | 24C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barre St. | | |

1 9 6 7 0 0 0 2 1 8 1



WILLIAM FORGE

WILLIAM FORGE

WILLIAM FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. 67 2175 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2175 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Minters William</i> | | 2. DATE AND HOUR OF DEATH <i>3/2/67</i> <i>2:12</i> P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>8-03</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>1706 Mura St</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i> <i>333</i> | | D. STREET ADDRESS (If rural, give location) <i>Baltimore Md</i> | | 5. SEX <i>Male</i> 6. RACE <i>Negro</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH <i>12-25-01</i> 9. AGE (In years last birthday) <i>65 yrs.</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Va.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Arthur Minters</i> | |
| 14. MOTHER'S MAIDEN NAME <i>Priscilla Pennington</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>215101759</i> | |
| 17. INFORMANT <i>Bessie Minters</i> | | ADDRESS <i>2706 Mura Street</i> | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Ventricular Fibrillation</i> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Surgical replacement aortic valve</i> | | 20. CAUSE OF DEATH <i>1 hr.</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 22. I certify that (1) (this hospital) attended the deceased from <i>3/1</i> 19 <i>67</i> to <i>3/2</i> 19 <i>67</i> , that (1) (we) last saw the deceased alive on <i>3/2</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | 23. DATE SIGNED <i>3/2/67</i> | |
| 24. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3-6-67</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Pk.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Arbutus Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 6 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i> | |
| 25C. FUNERAL DIRECTOR <i>Kelson Funeral Home</i> | | ADDRESS <i>1348 Calhoun St.</i> | | 26. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <i>3/2/67</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Aortic Insufficiency</i> 20A. AUTOPSY? (Yes or No) <i>Yes</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>No</i> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2176 | |
|--|------------------------|---|--|--|---|
| BIRTH NO. 67 2176 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) LEANA RAY GARNER | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 90 House In The Pines | | 2. DATE AND HOUR OF DEATH March 3, 1967 4:30 P. M. | | | |
| | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-02 D. STREET ADDRESS (If rural, give location) 2107 E. Coldspring Lane | | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH Oct. 21, 1895 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Union, S.C. | |
| 13. FATHER'S NAME Willie Ray | | | 14. MOTHER'S MAIDEN NAME Anna Ray | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 164-18-2442T | | 17. INFORMANT ADDRESS Dr. William Garner, 2107 E. Coldspring La. | |
| 18. 331X I CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) C-V-A DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 18 wks. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/1 19 66 to 2/26 19 67 , that (I) (we) last saw the deceased alive on 2/26 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Preston Grant | | | | 23B. DATE SIGNED 3/4/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS 601 N. Carroll St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-5-67 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Charles R. Law | | 25C. FUNERAL DIRECTOR ADDRESS 802 Madison Ave. | |

PAGE 2

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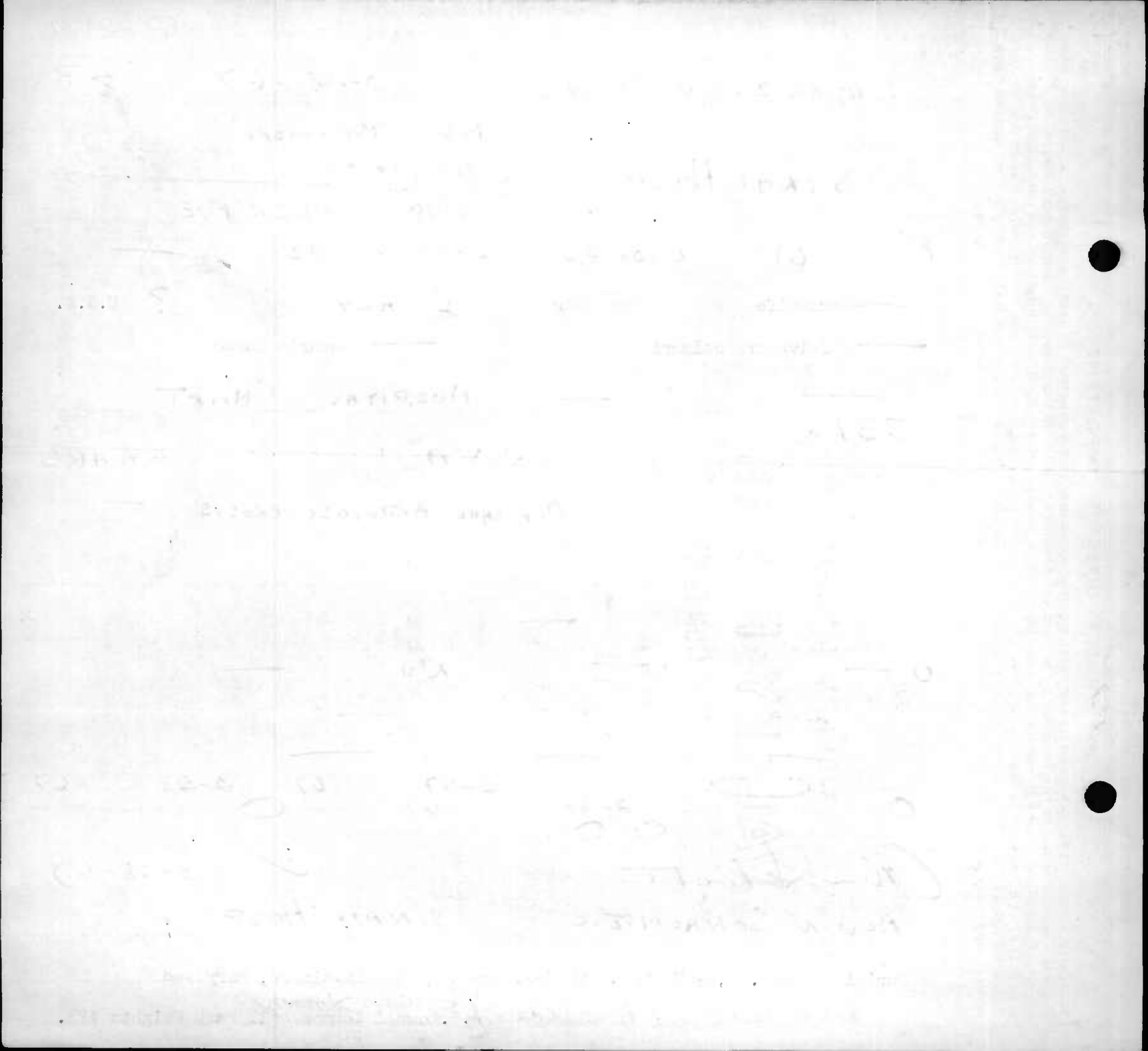
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2177 | |
|---|---------|--|------------------|--|--|
| BIRTH NO. 67 2177 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | CATANZARO JENNIE | | 2-28-67 8 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 42 SINAI HOSP. | | MD. BALTIMORE | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE 27-17 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 5310 WINNER AVE | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: Hours: Min. |
| F | W | WIDOWED | 6-6-86 | 80 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | Homemaker | | ITALY | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Salvatore Salmeri | | Rosaria Russo | | ? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | HOSPITAL CHART | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) CVA | | 24 HRS. | |
| ANTECEDENT CAUSES | | (B) CEREBRAL ARTERIOSCLEROSIS | | — | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-27 1967 to 2-28 1967, that (I) (we) last saw the deceased alive on 2-28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Alvin Schachter M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 2-28-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| ALVIN SCHACHTER M.D. | | | | SINAI HOSP. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | Mar. 4, 1967 | | New Cathedral Cemetery | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. GENERAL DIRECTOR ADDRESS | |
| MAR 6 1967 | | Robert E. Jenkins | | A.E. Lowell Jenmon 4611 Park Heights AVE. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2178 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2178 | |
|--|-------------------------|---|--------------------------------------|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ANNA S. BIRON | | | | 2. DATE AND HOUR OF DEATH MARCH 2, 1967 10 55 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BELVEDERE NURSING HOME 90 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE DISTRICT OF COLUMBIA B. COUNTY WASHINGTON C. CITY OR TOWN (If outside city limits, write RURAL and give township) V-48 D. STREET ADDRESS (If rural, give location) 2106 SPRUE DRIVE N.W. | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 2/10/1897 | | 9. AGE (In years last birthday) 86 | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME 1599C | | | | 14. MOTHER'S MAIDEN NAME BELLE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) --- | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Mrs. Jerome B. Chen - 6507 Western Run Dr. | | | |
| 18. 200.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Lymphosarcoma - (B) Guaranteed? (C) Interval between onset and death | | | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1959 to 3/4/67 , that (I) (we) last saw the deceased alive on 3/4/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Milton B. Kirsh | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/4/67 | |
| 23C. PHYSICIAN'S NAME (Type) Milton B. Kirsh, M.D. | | | | 23D. ADDRESS M.D. 4000 W. Northern Pkwy Baltimore - 21215 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/3/1967 | | 24C. NAME OF CEMETERY or CREMATORY HERRING RUN | | 24D. LOCATION (City, town, or county) (State) BALTO. MD | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR SYLVAN S. LEWIS & SON, INC. | | ADDRESS GARRISON, MD | |

Prostatectomy History

From White

1950
1951

—

Prostatectomy

1951

1952

1953

1954

1955

1956

1957

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 2179 | |
|--|-------------------------|--|------------------------------------|---|--|--|--|
| BIRTH NO. 67 2179 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>WILLIAM FORREST</u> | | | | 2. DATE AND HOUR OF DEATH <u>MARCH 3, 1967</u> <u>11:40 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>FRANKLIN SQUARE HOSPITAL</u> | | (If not in hospital or institution, give street address or location) | | A. STATE <u>MARYLAND</u> | | B. COUNTY <u>Baltimore</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE COUNTY</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>333 DIXIE DRIVE 04</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>8/27/86</u> | 9. AGE (In years last birthday) <u>80</u> | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City Police Dept.</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>JOSEPH WILLIAM FORREST SR.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE LARAGY</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>220-46-5808</u> | | 17. INFORMANT <u>CHART - Hosp.</u> | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>422.1</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) <u>BILATERAL PNEUMONIA</u> DUE TO | | | |
| | | | | (B) <u>CARDIOVASCULAR ACCIDENT</u> DUE TO | | | |
| | | | | (C) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <u>2/2</u> 19 <u>67</u> to <u>3/3</u> 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>3/3</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Ferdinand C. Rodriguez</u> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>3/3/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>FERDINAND C. RODRIGUEZ</u> | | | | 23D. ADDRESS <u>FRANKLIN SQUARE HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/7/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Dulaney Valley Memorial Gardens</u> | | 24D. LOCATION (City, town, or county) (State) <u>Cockeysville Md.</u> | |
| 25A. DATE RECEIVED BY HEALTH DEPT. <u>MAR 6 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Sullivan</u> | | 25C. FUNERAL DIRECTOR <u>John J. Cowan</u> | | ADDRESS <u>901 Hollins St. 23 Md.</u> | |

NEW YORK
JAN 10 1964

TO THE DIRECTOR
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

FROM: [illegible]
SUBJECT: [illegible]
RE: [illegible]

DATE: [illegible]

REFERENCE IS MADE TO
YOUR LETTER OF [illegible]
DATED [illegible]

Yours very truly,
[illegible]

Enclosed for the Bureau are
three copies of a letterhead memorandum
dated and captioned as above.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-400

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2180 | |
|--|------------------------|--|--|--|---|
| BIRTH NO. 67 2180 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Edward J. Kelly</u> | | 2. DATE AND HOUR OF DEATH <u>3/3/67</u> <u>2:30 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hospital</u> <u>38</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Balt</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1535 Light St</u> <u>24-04</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Cauc</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never Married</u> | 8. DATE OF BIRTH <u>11/25/04</u> <u>64-62</u> | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>B+O Railroad-Retired Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>USA-Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Leo J. Kelly</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Margaret Henricks</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u> <u>No</u> | | | |
| 16. SOCIAL SECURITY NO. <u>216-03-34</u> | | 17. INFORMANT <u>83 Mrs. Margaret Tormollan, 1814 Byrd St</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>420.1 I</u> | | CAUSE OF DEATH (A) DUE TO <u>Cardiovascular Collapse 48h</u> (B) DUE TO <u>Acute Myocardial Infarction ?</u> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Ooy) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> 19 <u>67</u> to <u>3/3</u> 19 <u>67</u> . that (I) (we) last saw the deceased alive on <u>3/3</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>David A. Shafritz</u> M.O. | | | | 23B. DATE SIGNED <u>3/3/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>David A. Shafritz</u> M.O. | | | | 23D. ADDRESS <u>Univ. Hosp.</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-7-67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd. Balto. Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>3-7-67</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Jackson</u> | | 25C. FUNERAL DIRECTOR <u>John D. Fleming</u> <u>422 Light St. Balto. Md.</u> | | | |

MAR 6 1967

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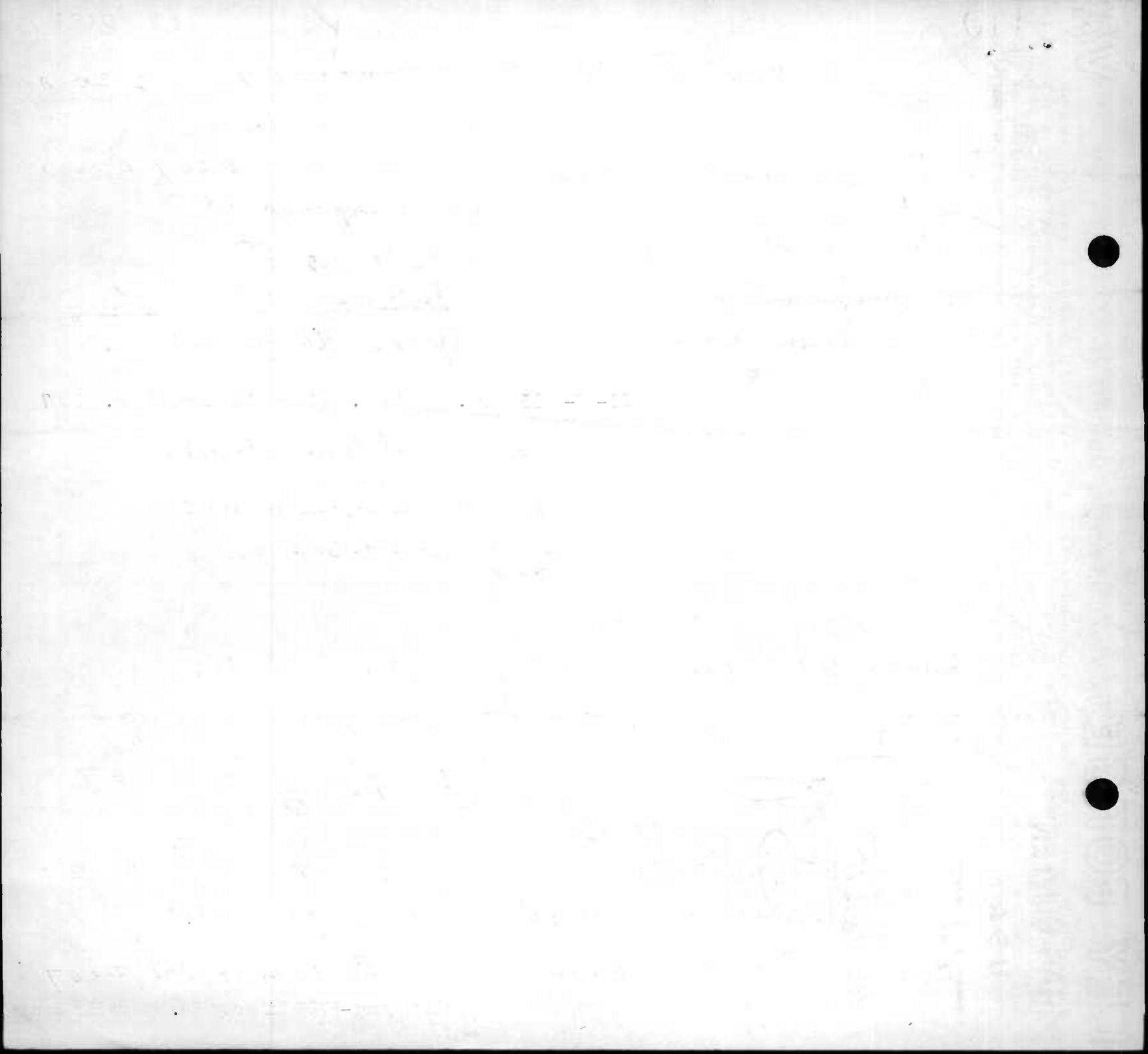
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|--|---|---|
| BIRTH NO. 67 2181 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 67 2181 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ARTHUR KLIPP | | | 2. DATE AND HOUR OF DEATH 3-2-67 2:30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MEERBY Hosp. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21207 53-00 D. STREET ADDRESS (If rural, give location) 6442 Dogwood Rd. | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 2-5-02 | 9. AGE (In years lost birthday) 65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop man | | 10B. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME William Klipp | | | 14. MOTHER'S MAIDEN NAME Grace De Grange | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-05-2935 | 17. INFORMANT ADDRESS Mrs. Jessie I. Klipp-6442 Dogwood Rd. 21207 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 163X 11-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Carcinoma of lung, metastatic to liver, bowel ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. ASCVD & Diabetes mellitus (C) Cataract 2° to Diabetes, BPH | | | CAUSE OF DEATH Interval BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Anemia | | | | | |
| 19A. DATE OF OPERATION 1-19-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of lung | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that this hospital attended the deceased from 1-18-67 19 to 3-2-67 , that (I) (we) lost saw the deceased alive on 3-2-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Stephan J. Wittmann M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 3-2-67 | | |
| 23C. PHYSICIAN'S NAME (Type) STEPHAN J. WITTMANN | | | 23D. ADDRESS MEERBY Hosp. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/6/67 | | 24C. NAME OF CEMETERY or CREMATORY Woodlawn | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md 21207 | | 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Jackson | | 25C. FUNERAL DIRECTOR ADDRESS Loring Byers-8728 Liberty Rd. Randallstown | | | |



1
M-635

67 2182

BALTIMORE CITY HEALTH DEPARTMENT

67 2182

BIRTH NO. 66-27516

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

L.

Sharon Martin

2. DATE AND HOUR PRONOUNCED DEAD

3/2/67 11:20 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

40

St. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4745 Aldgate Green

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

12-25-1966

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

2 5

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Charles C. Martin

14. MOTHER'S MAIDEN NAME

Mazie R. Schmidt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Charles C. Martin, 4745 Aldgate Green

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Interstitial pneumonia (SDII)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/2/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-4-1967

23C. NAME OF CEMETERY or CREMATORY

Meadowridge Cemetery

23D. LOCATION

(City, town, or county)

(State)

Howard County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 6

1967

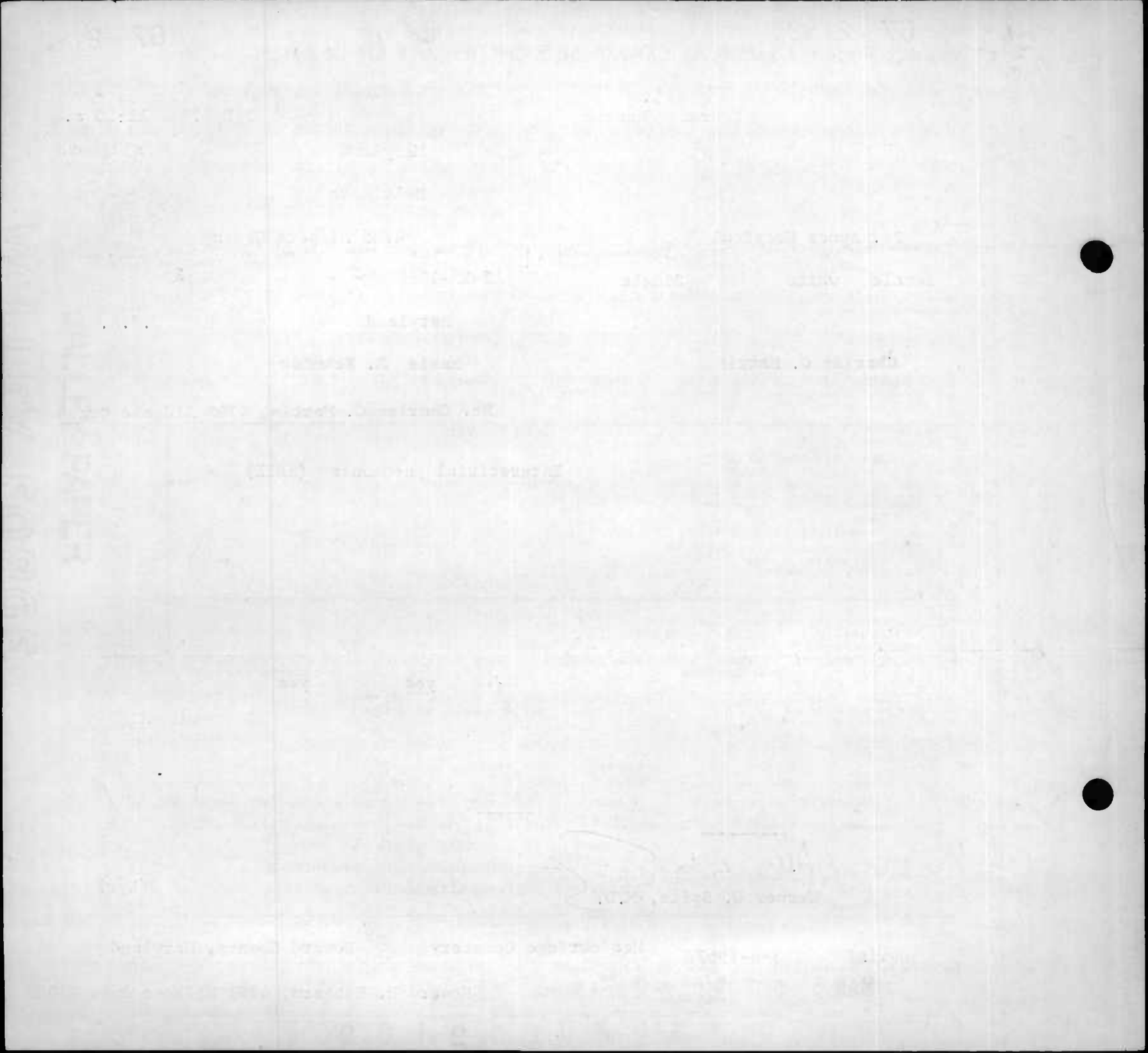
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

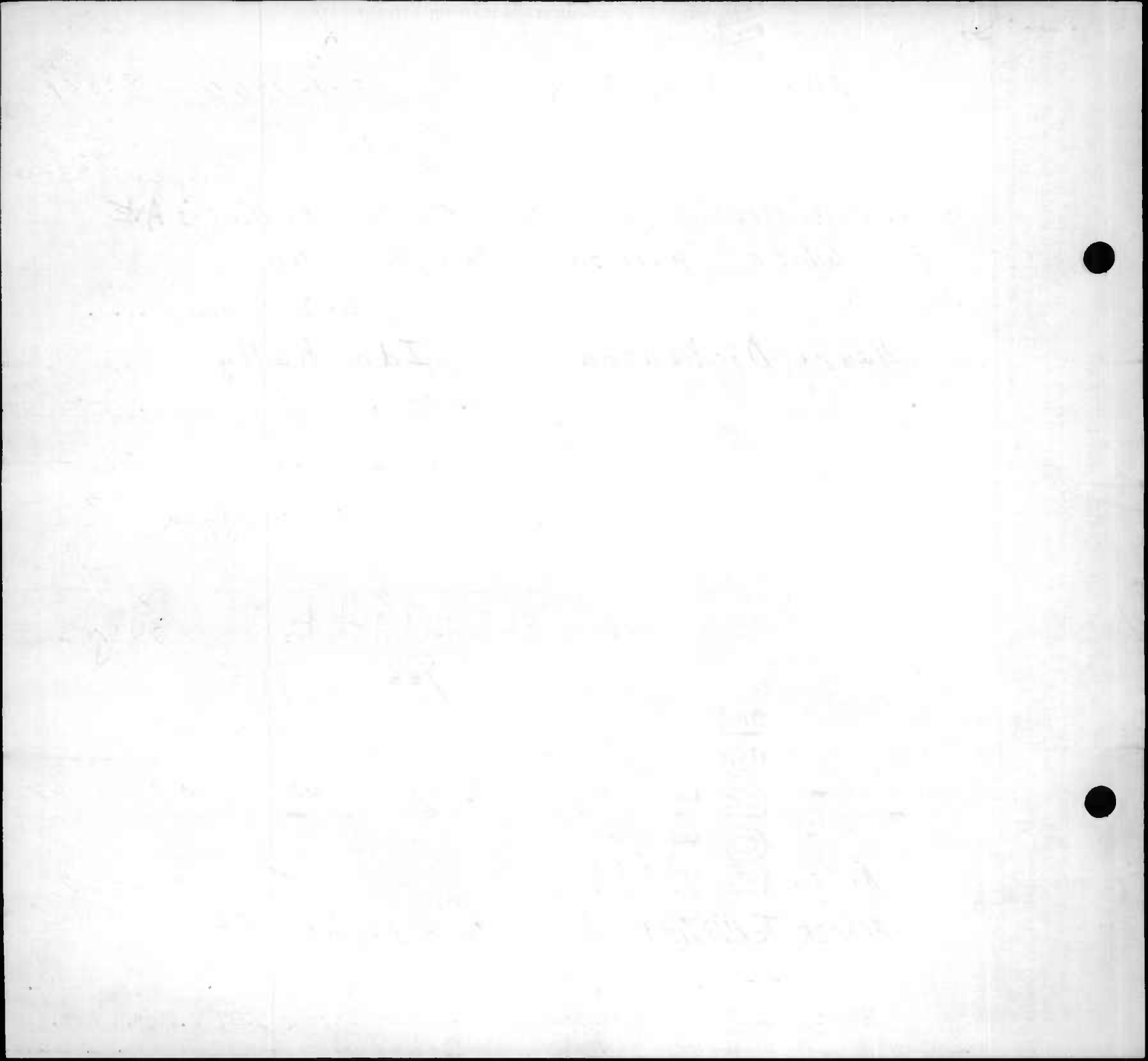
ADDRESS

Howard H. Hubbard, 4107 Wilkens Ave. 21229



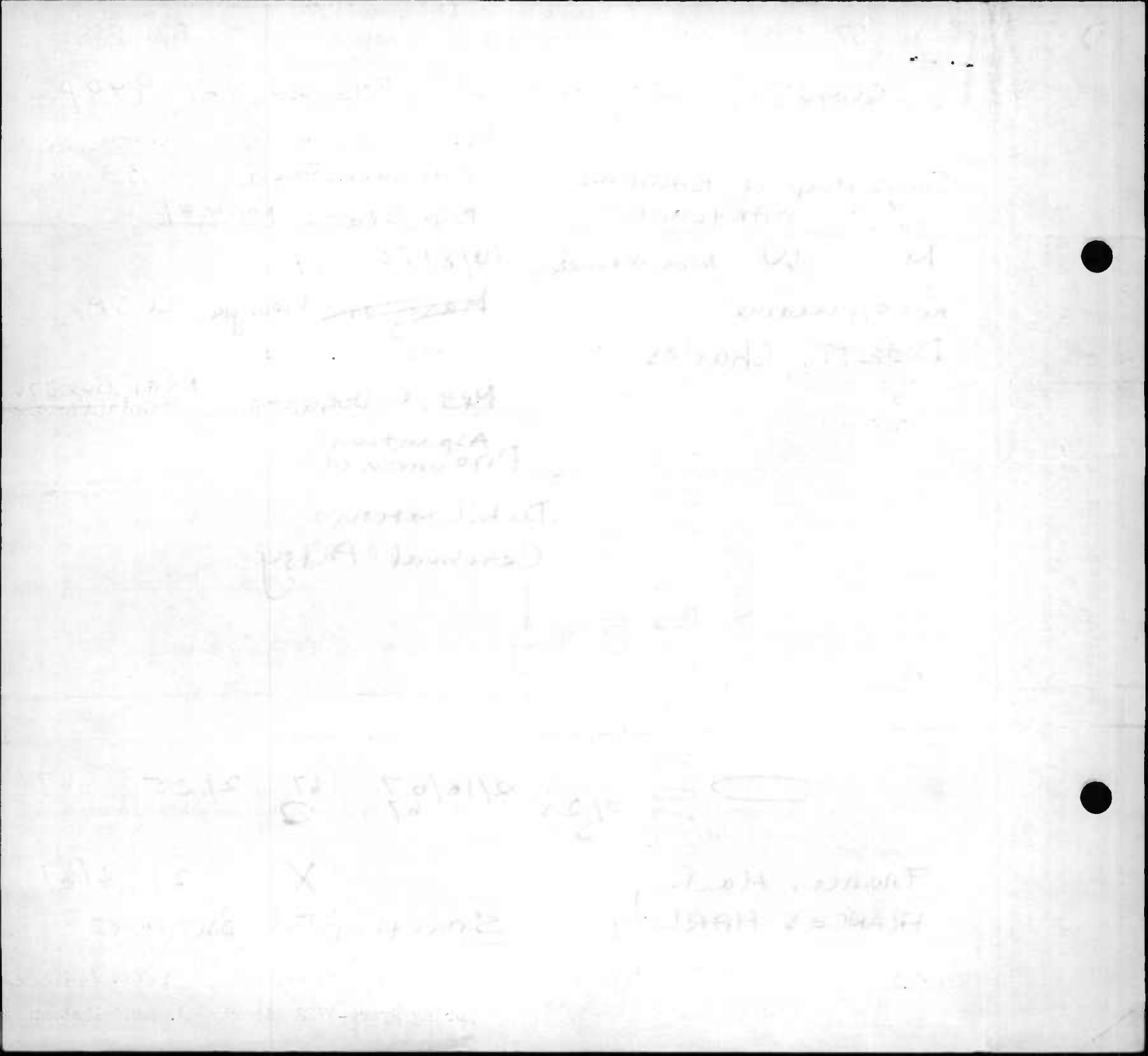
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. 67 2183 | |
|---|-------------------------|---|--------------------------------------|---|--|
| BIRTH NO. 67 2183 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) Birdie A. Phillips | | 2. DATE AND HOUR OF DEATH 3-1-1967 8:05 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF INSTITUTION 43 South Baltimore General Hosp. | | A. STATE Maryland B. COUNTY Balt. Co. | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #2120753-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) 5603 St. Mary's Ave. | | | |
| 5. SEX F | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9-18-1900 | 9. AGE (In years last birthday) 66 | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) W. Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Henry Dickenson | | 14. MOTHER'S MAIDEN NAME Ida Kelly | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. John A. Phillips 5603 St. Mary's Ave. | |
| 18. 5-02.01 | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Bronchopneumonia 1 wk. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Chronic bronchitis + Emphysema ? | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) ASCVD Severe Rheumatoid Arthritis | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that this (this hospital) attended the deceased from 2-28 19 67 to 3-1 19 67 , that the (we) last saw the deceased alive on 3-1 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert T. Miller | | | | 23B. DATE SIGNED 3-2-67 | |
| 23C. PHYSICIAN'S NAME (Type) Albert T. Miller | | | | 23D. ADDRESS 1213 Light St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-4-1967 | | 24C. NAME OF CEMETERY or CREMATORY Good Shepherd | |
| 24D. LOCATION (City, town, or county) Howard Co. | | 24E. STATE Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2181</u> | |
|--|---------------------|--|---|--|--|
| BIRTH NO. <u>67 2184</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>DOGGETT, STEPHEN D.</u> | | 2. DATE AND HOUR OF DEATH <u>Feb. 25, 1967 9:40 p. M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hosp of BALTIMORE</u> <u>42 Maryland.</u> | | | A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Randalls Town</u> <u>53-00</u> D. STREET ADDRESS (If rural, give location) <u>Box 376 - Route #1</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u> | 8. DATE OF BIRTH <u>10/8/52</u> | | 9. AGE (In years lost birthday) <u>14</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>not employable</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Marionland Georgia</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 13. FATHER'S NAME <u>DOGGETT, Charles S.</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>Geraldine F. Searcy</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT <u>MRS. C. DOGGETT</u> | | |
| 18. 334X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Aspiration Pneumonia</u> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO <u>Debilitation</u> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (B) DUE TO <u>Cerebral Palsy</u> | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/18/67</u> 19 <u>67</u> to <u>2/25</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/25</u> 19 <u>67</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Frances Harley</u> | | | | 23B. DATE SIGNED <u>2/25/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>FRANCES HARLEY</u> | | | | 23D. ADDRESS <u>Sinai Hospital, BALTIMORE</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-3-1967</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Forrest Park</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Shreveport Louisiana</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 6 1967</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown</u> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2185 | |
|---|-------------------------|---|--------------------------------------|--|---|
| BIRTH NO. 67 2185 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Lewis, MARIA, J | | 2. DATE AND HOUR OF DEATH 3-4-67 10⁴⁵ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION George Washington Nursing Home 607 Pennsylvania Ave. | | A. STATE md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 17-01 D. STREET ADDRESS (If rural, give location) 607 Pennsylvania | | | |
| 5. SEX Female | 6. RACE negro | 7. MARRIED, NEVER MARRIED WIDOWED , DIVORCED (specify) | 8. DATE OF BIRTH 3/30/1871 | 9. AGE (In years last birthday) 95 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ? | | | 14. MOTHER'S MAIDEN NAME ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 218-30-5631 | | 17. INFORMANT Chart. | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Ante Coronary Occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, ASCVD disease | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 5-6 hrs unknown | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/7 19 60 to 3/4 19 67 , that (I) (we) lost saw the deceased alive on 3/4 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | |
| 23A. SIGNATURE E.E. Holt | | | | 23B. DATE SIGNED 3/6/67 | |
| 23C. PHYSICIAN'S NAME (Type) E.E. Holt | | | | 23D. ADDRESS 3715 Liberty Hgts. Ave. Baltimore, Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/67 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary | |
| 24D. LOCATION (City, town, or county) (State) Glen Burnie Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | |
| 25B. NAME OF REGISTRAR Paul E. Taylor | | 25C. FUNERAL DIRECTOR Wm P Carroll | | | |
| 25D. ADDRESS 1712 W. Work Ave | | | | | |

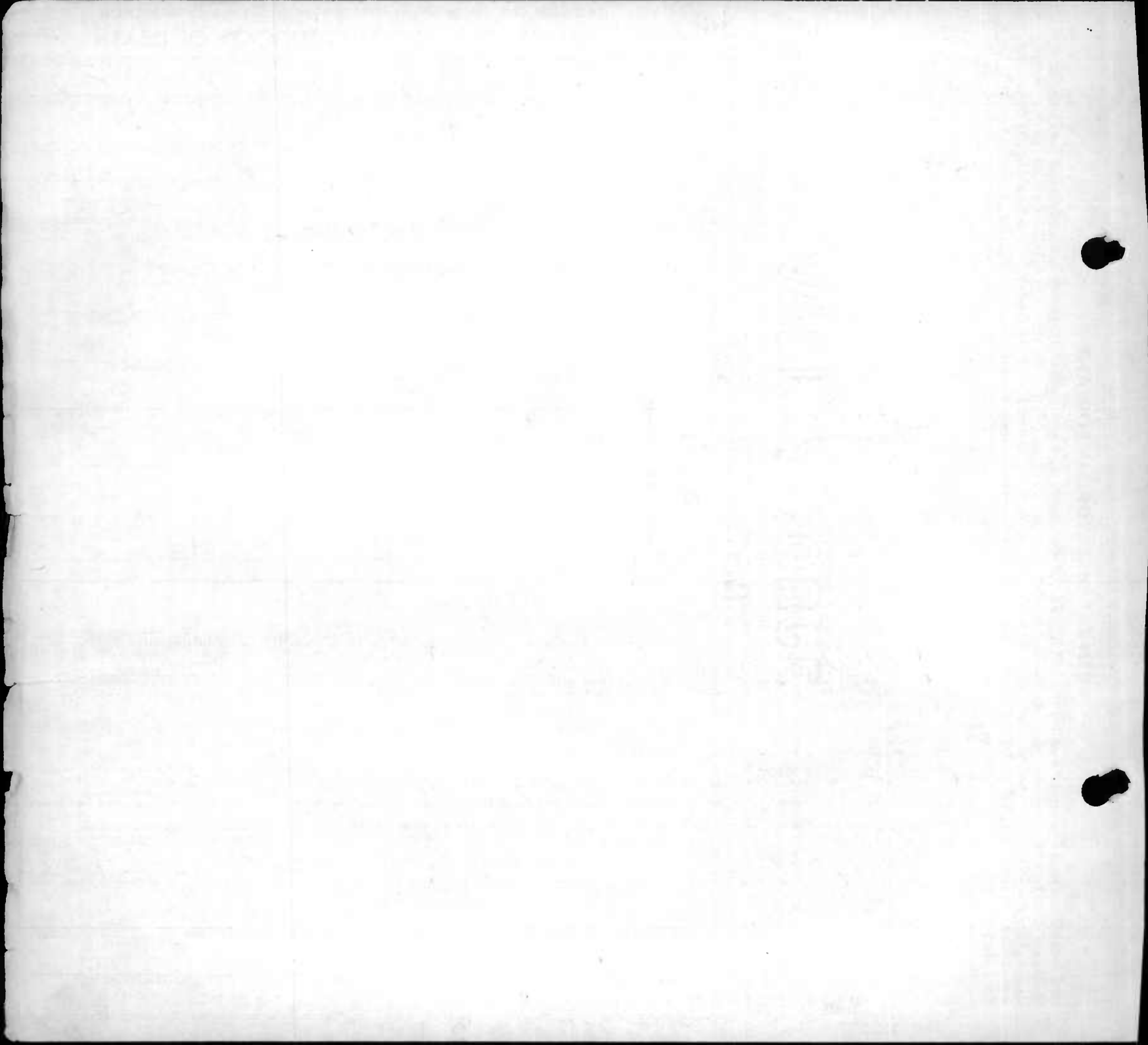
NEW YORK

UNITED STATES

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2186 | |
|---|---------------------|---|-----------------------------------|--|--|
| BIRTH NO. 67 2186 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>DARVUS McSwain</i> | | 2. DATE AND HOUR OF DEATH <i>2/20/67 7 40 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital.</i> | | | | A. STATE <i>Md.</i> | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baito- 401</i> | |
| | | | | O. STREET ADDRESS (If rural, give location) <i>514 E. Pratt St</i> | |
| 5. SEX <i>m</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>5/9/33</i> | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Oays If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <i>581.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) <i>Laennec's Cirrhosis</i> | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) OUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>CHF</i> | | | | (C) OUE TO | |
| 19A. DATE OF OPERATION <i>2/19/67</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Tracheostomy - Resp distress</i> | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/19 1967</i> to <i>2/20 1967</i> that (I) (we) last saw the deceased alive on <i>2/20 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Philip B. Gorkin</i> | | | | 23B. DATE SIGNED <i>2/21/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE <i>2-4-67</i> | | 24C. NAME OF CEMETERY or CREMATORY | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 6 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</i> | |



1
W-325

67 2187

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2187

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN T. WATSON

2. DATE AND HOUR PRONOUNCED DEAD

February 14, 1967 3:55 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 135 N. Broadway

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

135 N. Broadway

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

55

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Acute and Chronic Pancreatitis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE
EXAMINER'S NAME (Type)

Rudiger Breitenacker, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

2/15/67

23A. BURIAL CREMATION, REMOVAL (Specify)

23B. DATE

2-28-67

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 6 1967

MORTUARY SERVICE - BCHD

1 9 6 7 0 0 0 2 1 9 4

12/2/74

WILLIAM L. BRYANT
JANUARY 1, 1975

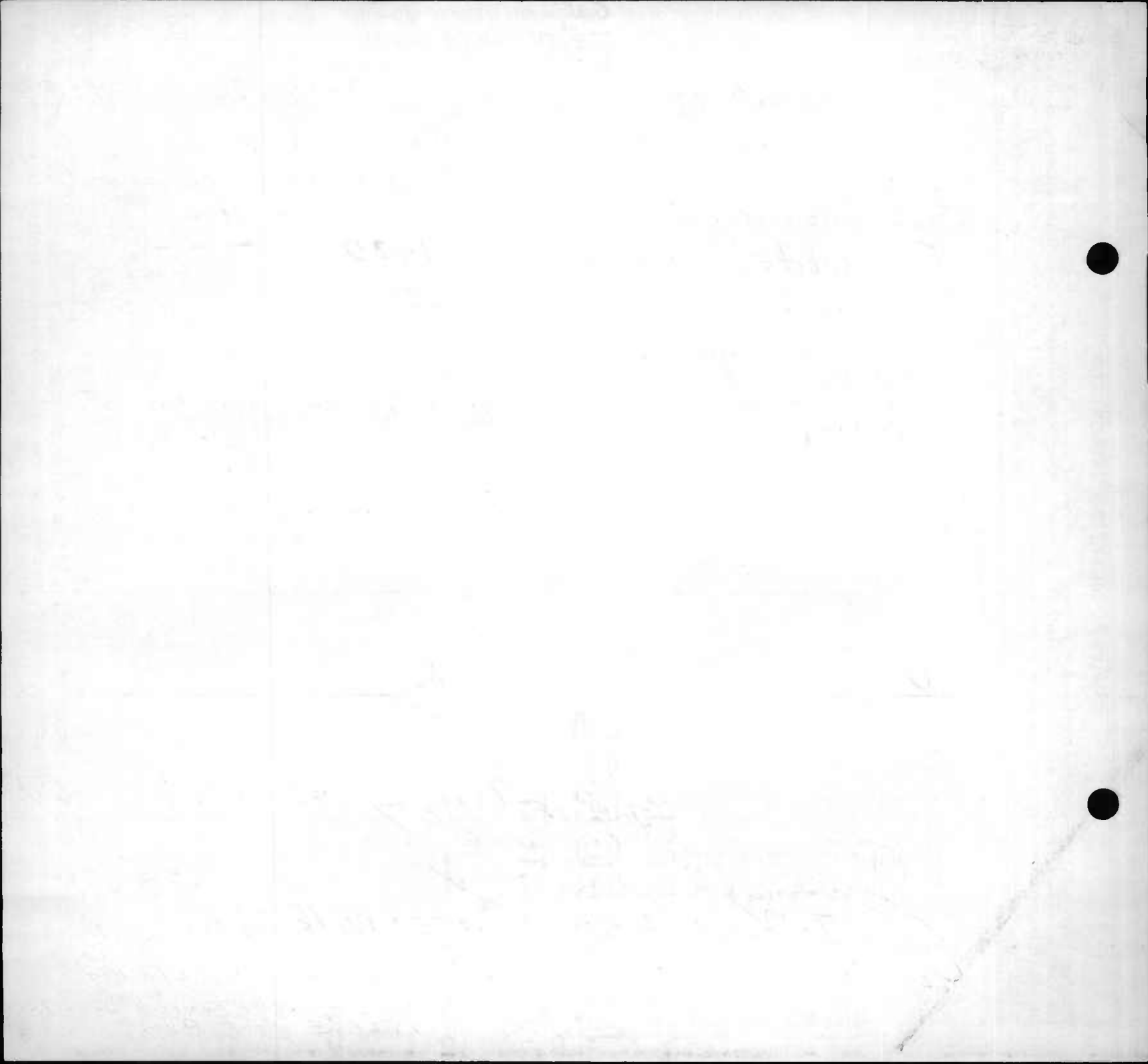
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100-100000-100000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2188 | |
|---|----------------------|---|---|---|--|
| BIRTH NO. 67 2188 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Opa IV Day | | | 2. DATE AND HOUR OF DEATH 2-24-1967 8:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hosp. (If not in hospital or institution, give street address or location) | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1624 E. Fort Ave. | | |
| 5. SEX F | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH 1920 | 9. AGE (In years last birthday) 47 | 10. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barmaid | | | 11. BIRTHPLACE (State or foreign country) West Virginia | | |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 219-10-9933 | | |
| 17. INFORMANT James Papiolok | | | ADDRESS 1459 Hull St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenia, etc. It means the disease, injury or complication which caused death.) 420.11 Coronary insufficiency arterioscl. cardiovascular disease 4 yrs | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 7 19 63 to Feb 19 67 that (I) (we) last saw the deceased alive on Feb 18 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Quinn A. Brudel M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 3.3.67 | |
| 23C. PHYSICIAN'S NAME (Type) J. KUDIRKA M.D. | | | | 23D. ADDRESS 2151 Wilkens Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/4/67 | | 24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park | |
| 24D. LOCATION (City, town, or county) Anna Arundel, Md. | | 24E. STATE (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR Robert E. Stanley, M.D. | | 25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. ADDRESS 1501 E. Fort Ave. | |

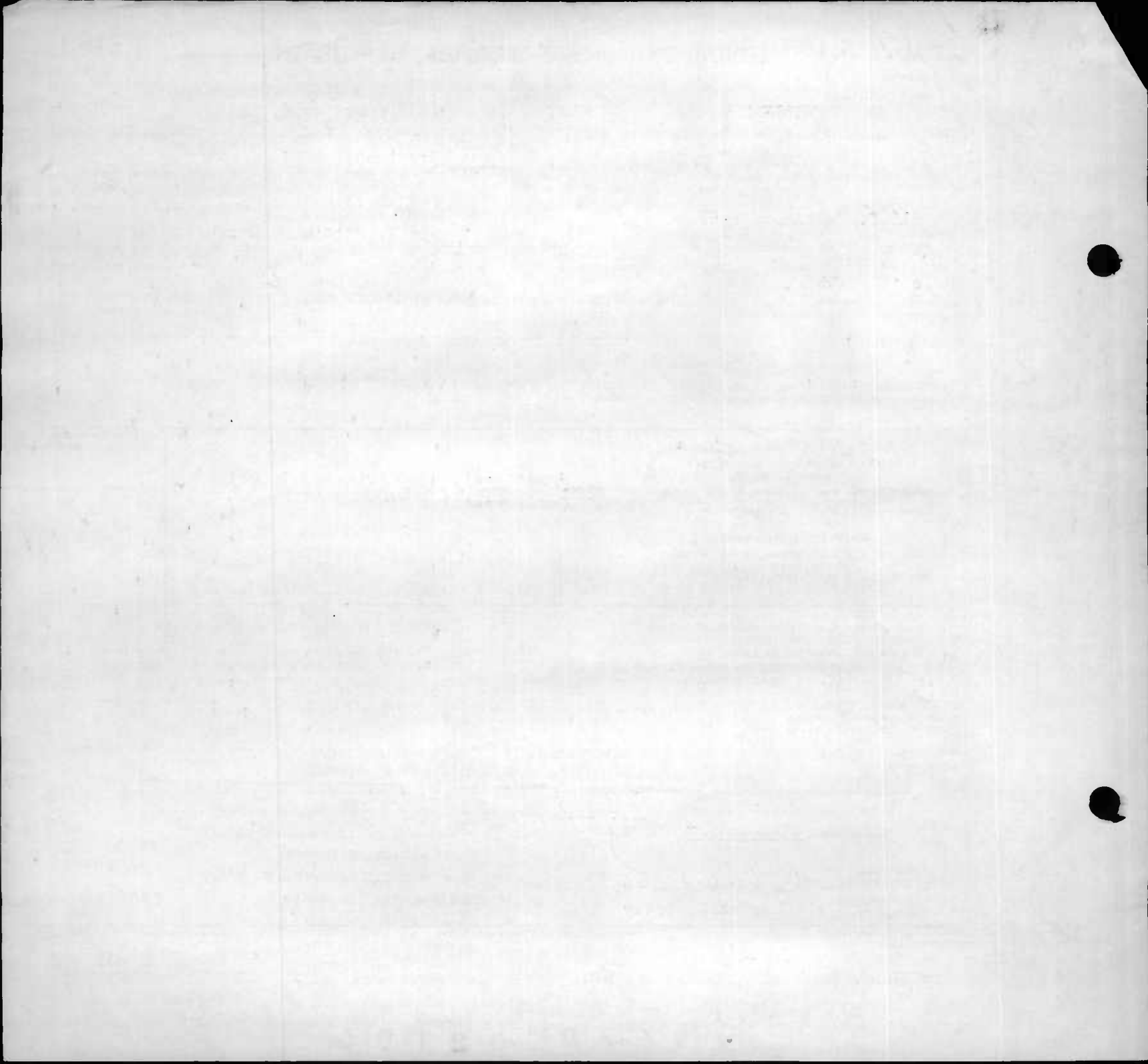


BIRTH NO. **67 2189** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 2189**

M.E. CASE NO.

| | | | |
|---|-------------------------|--|---|
| 1. NAME OF DECEASED (Type or Print) WILLIAM CANADY | | 2. DATE AND HOUR PRONOUNCED DEAD February 6, 1967 12:35 P | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 916 W. Baltimore Street | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 1801 D. STREET ADDRESS (If rural, give location) 916 W. Baltimore Street | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 64 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |

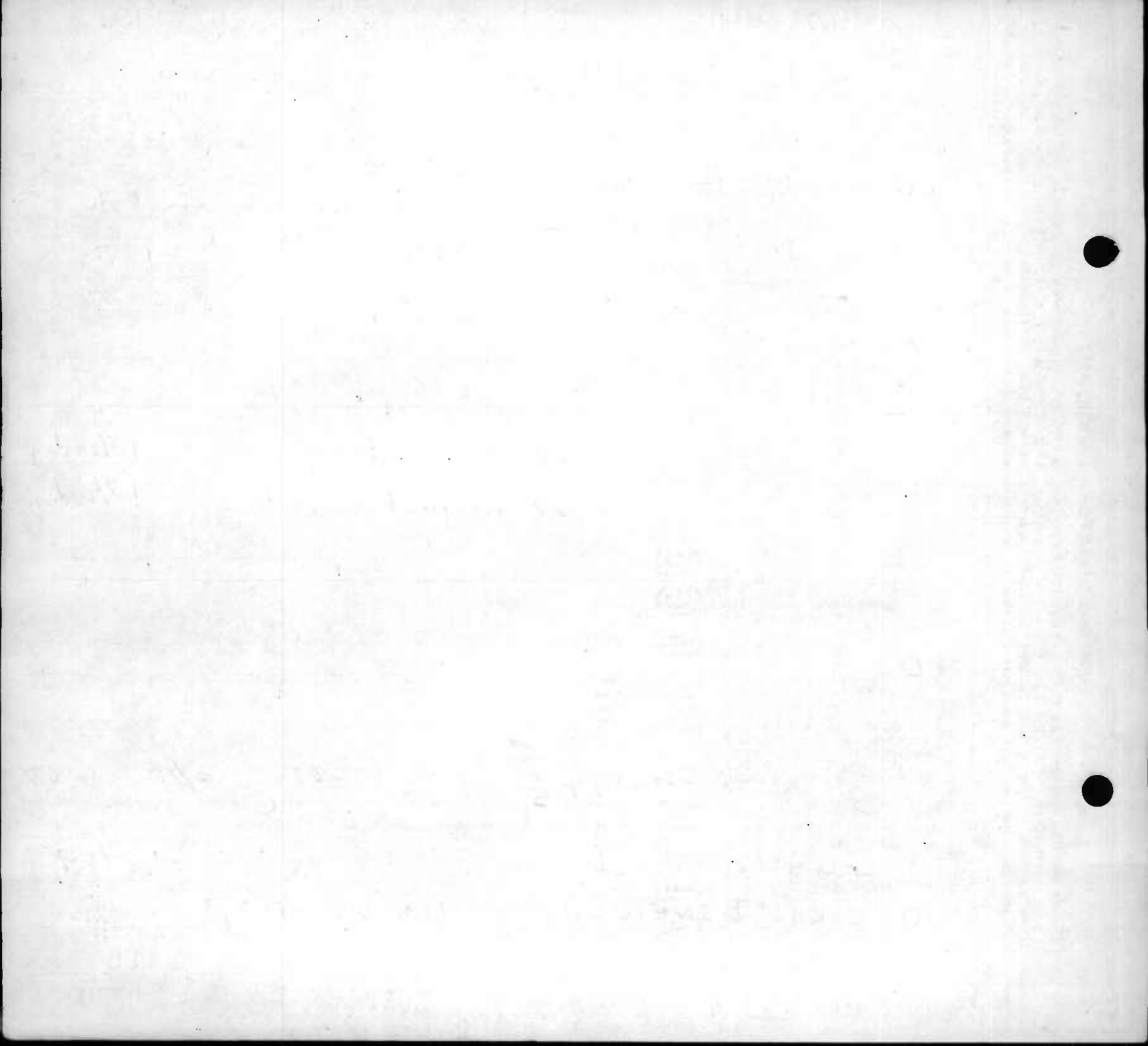
| | | | |
|---|---|--|--|
| 18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive and Arteriosclerotic Cardiovascular Disease. | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Petty</i> M.D. Charles S. Petty EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE 2-28-67 | 23C. NAME OF CEMETERY or CREMATORY |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 24B. NAME OF REGISTRAR <i>Robert E. Farley</i> | 24C. FUNERAL DIRECTOR ADDRESS MAR 6 1967 Robert E. Farley |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

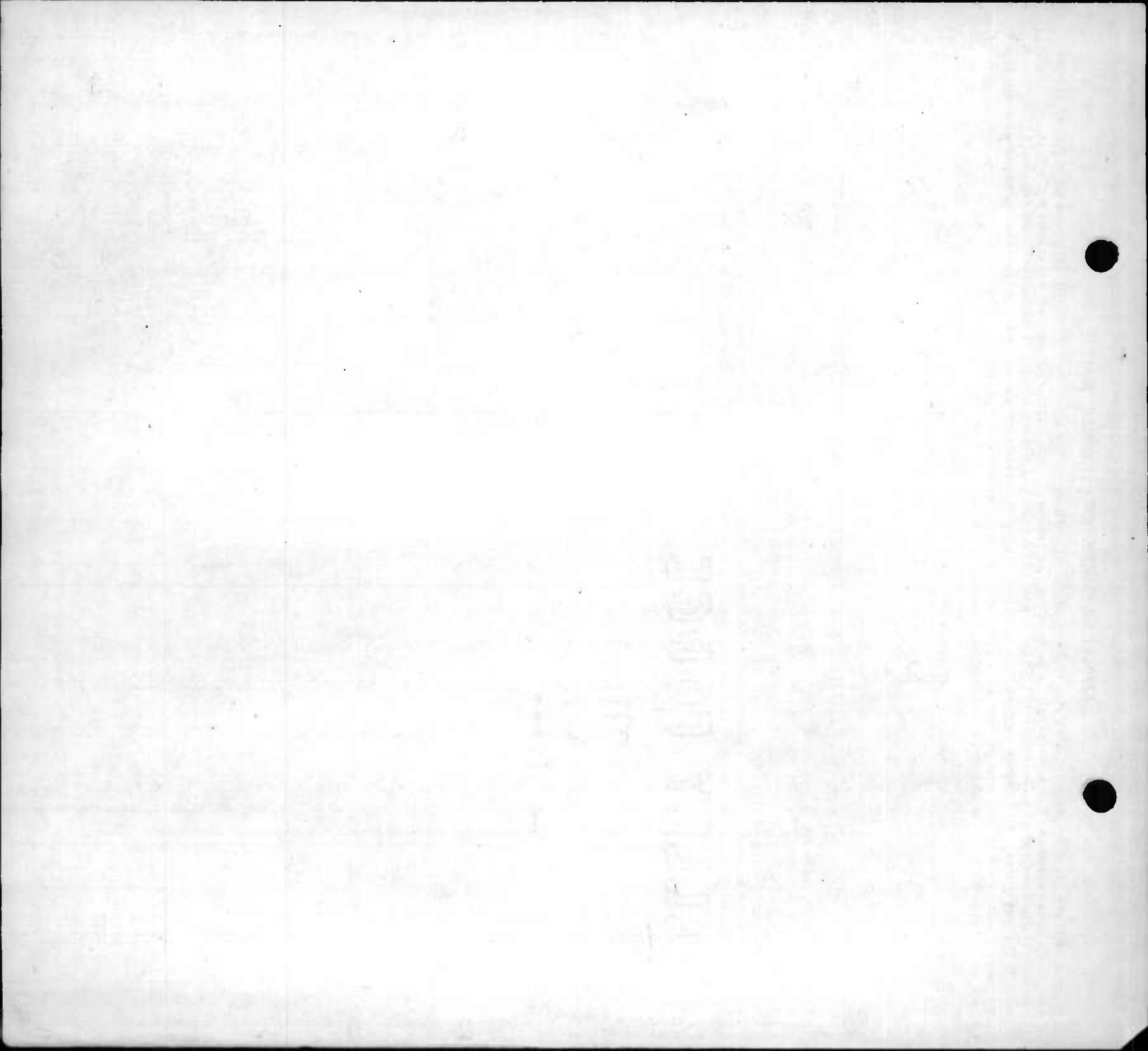
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|------------------|--|--|---|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2190 | | | | |
| BIRTH NO. 67 2190 M.E. CASE NO. 67-03228 1. NAME OF DECEASED (Type or Print) Baby Girl Hill "B" | | | | | 2. DATE AND HOUR OF DEATH 2/15/67 - 9pm | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Md B. COUNTY X C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 2208 Norfolk Ave #30 | | | | |
| 5. SEX F | | 6. RACE N | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 2/14/67 | | 9. AGE (In years lost birthday) 1 7 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Not married Frederick Hill | | | | | 14. MOTHER'S MAIDEN NAME Loretta | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS D. Gary Benfield, MD | | | |
| 18. 773.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | (B) Premature DUE TO | | | 1 7/24 day. | |
| | | | (H) Respiratory Distress DUE TO | | | 1 7/24 day. | | | |
| | | | (C) | | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/14 19 67 to 2/15 19 67 , that (I) (we) last saw the deceased alive on 2/15 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE D. Gary Benfield M.D. | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/15/67 | |
| 23C. PHYSICIAN'S NAME (Type) D. GARY BENFIELD M.D. | | | | | | 23D. ADDRESS UNIV. HOSP | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | | 24B. DATE 2-28-67 | | 24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL | | 24D. LOCATION (City, town, or county) (State) | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | | 25C. FUNERAL DIRECTOR ADDRESS MORTUARY SERVICE - BCHD | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--------------|--|--|--|---|
| BIRTH NO. 67 2191 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2191 4 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Baby Boy Potts | | 2. DATE AND HOUR OF DEATH 1/20/67 10:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 University of Maryland Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-12 | | | |
| | | D. STREET ADDRESS (If rural, give location) 3837 Reisterstown Road | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) never married | 8. DATE OF BIRTH 1/20/67 | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Infant) | | 10B. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) Md. - Univ. Hosp. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Louis Elbert Potts | | 14. MOTHER'S MAIDEN NAME Rebecca McIver | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mother 3837 Reisterstown Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 776 X I Prematurity | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2/1 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9:21 a.m. Jan 20 1967 to 10:30 a.m. Jan 20 1967, that (I) (we) last saw the deceased alive on 10:29 a.m. Jan 20 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jane E. McElafferty | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 1/26/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. ANATOMY BLDG. OF MARYLAND UNIVERSITY MEDICAL SCHOOL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 2-28-67 | | 24C. NAME OF CEMETERY or CREMATORY | |
| | | | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Philip E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS HOSPITAL DISPOSAL | |
| MAR 6 1967 | | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)LYNETTE
KATHEY ~~44444~~ Taylor

2. DATE AND HOUR PRONOUNCED DEAD

3/5/67 3:27 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

42 Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Timonium - rural 53-00

D. STREET ADDRESS (If rural, give location)

4 Washington St.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Feb. 2, 1950

9. AGE (in years
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cosmetic

10B. KIND OF BUSINESS OR INDUSTRY

Robert Hall
Clothing

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Reeves Tayler

14. MOTHER'S MAIDEN NAME

Ethel Wood

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

???

17. INFORMANT

ADDRESS

Ethel Martin, Same as # 4

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Multiple injuries

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

beltway

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Stevenson Lane and Park Hghts. Ave. 53-00

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3 5 67 2:10 a.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

passenger in auto into fixed object

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

3/5/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Mar. 8, 1967

23C. NAME of CEMETERY or CREMATORY

Jessops Cemetery

23D. LOCATION

(City, town, or county)

(State)

Sparks, Baltimore Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks Towson, 1050 York Road

Towson 4, Maryland

MAR 6 1967

7-460 67 2192

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|---|--|---|--|
| <p>W-3514</p> <p style="font-size: 24pt;">67 2193</p> <p style="font-size: 24pt;">BIRTH NO.</p> | | <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt;">CERTIFICATE OF DEATH</p> | | <p>Registered No. 67 2193</p> | |
| <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <i>John P. Weidemuller</i></p> | | <p>2. DATE AND HOUR OF DEATH <i>3/4/67 11:35 P.M.</i></p> | | | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p style="font-size: 24pt;">CERTIFICATE AMENDED</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i></p> | | <p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i></p> | | | |
| <p>5. SEX <i>Male</i></p> | | <p>6. RACE <i>White</i></p> | | <p>7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i></p> | |
| <p>8. DATE OF BIRTH <i>11/26/89</i></p> | | <p>9. AGE (In years last birthday) <i>77</i></p> | | <p>10. AGE (In years last birthday) <i>77</i></p> | |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Accountant</i></p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY <i>West Penn Power Co</i></p> | | <p>11. BIRTHPLACE (State or foreign country) <i>New Jersey</i></p> | |
| <p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p> | | <p>13. FATHER'S NAME <i>John Weidemuller</i></p> | | <p>14. MOTHER'S MAIDEN NAME <i>Rose T. Cook</i></p> | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i></p> | | <p>16. SOCIAL SECURITY NO. <i>190-09-5944</i></p> | | <p>17. INFORMANT <i>Harold Chant</i></p> | |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH <i>Uremia</i></p> | | <p>INTERVAL BETWEEN ONSET AND DEATH</p> | | | |
| <p>19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | <p>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | |
| <p>21A. DATE OF OPERATION</p> | | <p>21B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>21C. AUTOPSY? (Yes or No) <i>No</i></p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | |
| <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p> | | <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (1) (this hospital) attended the deceased from <i>2/2/67</i> 19<i>67</i> to <i>3/4/67</i> 19<i>67</i>, that (1) (we) last saw the deceased alive on <i>3/4/67</i> 19<i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</p> | | | | | |
| <p>23A. SIGNATURE <i>[Signature]</i></p> | | <p>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p> | | <p>23B. DATE SIGNED <i>3/4/67</i></p> | |
| <p>23C. PHYSICIAN'S NAME (Type)</p> | | <p>23D. ADDRESS <i>Wm. Cook-Brooks Towson, 1050 York Road Towson 4, Maryland</i></p> | | | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i></p> | | <p>24B. DATE <i>March 7, 1967</i></p> | | <p>24C. NAME OF CEMETERY OR CREMATORY <i>Gardens Of Faith</i></p> | |
| <p>24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i></p> | | <p>25A. DATE REC'D BY HEALTH DEPT.</p> | | <p>25B. NAME OF REGISTRAR <i>Wm. Cook-Brooks</i></p> | |
| <p>25C. FUNERAL DIRECTOR <i>Wm. Cook-Brooks</i></p> | | <p>25D. ADDRESS <i>Towson, 1050 York Road Towson 4, Maryland</i></p> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Approved by Medical Examiner & Release from Hosp. 2194

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 67 2194

| | | | | | | | |
|--|---------|---|---|--|---------------------------------|--|------------------------------|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Smith, Mabel Rigney | | 03-05-67 4:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | | | A. STATE Md. | | | |
| CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | B. COUNTY | | | |
| Balt. | | | | 27-12 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | Long Green Nursing Home | | | |
| 5. SEX | 6. RACE | 7. MARRIED | NEVER MARRIED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. |
| F | W | <input checked="" type="checkbox"/> WIDOWED | <input type="checkbox"/> DIVORCED (specify) | 07-30-78 | 88 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| housewife | | | | | | Md. Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| F. Winthrop Whitman | | | | Lillie Rigney | | | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No. | | | | | | Hospital Records | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES | | | | (A) Generalized Arteriosclerotic Cardiovascular Disease | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Rt. Hip Fracture | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. | | | | (C) | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 02-15-67 | | | | Fair | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| Nursing Home | | | | Nursing Home | | 115-12000 Ave | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 02-02-67 | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | Fell 27-12 | |
| 22. I certify that (I) (this hospital) attended the deceased from 02-02-67 to 03-05-67, that (I) (we) last saw the deceased alive on 03-05-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Hyonzlok Lee | | | | | | 03-05-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Hyonzlok Lee | | | | Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 3,7,67 | | Druid Ridge | | Baltimore, Md. | |
| 25A. DATE RECEIVED BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| MAR 6 1967 | | Robert E. Talley, M.D. | | Wm. Cook-Brooks Towson, Towson, Md. | | 21204 | |

2nd M. W. P. 1st

F W O

F. W. P. 1st

St. H. v. P. 1st
C. v. P. 1st
C. v. P. 1st

F. W. P. 1st

05-12-11

W. P. 1st

05-05-11

03-02-11
05-05-11
03-02-11

W. P. 1st

x

03-02-11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------|--|--|--|--|
| BIRTH NO. 67 2195 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 34-00-61 | |
| M.E. CASE NO. 67 2195 | | CERTIFICATE OF DEATH | | 67 2195 | |
| 1. NAME OF DECEASED (Type or Print) Baby Boys Cooper, Newbern | | 2. DATE AND HOUR OF DEATH Jan. 31, 1967 12:10 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital | | A. STATE B. COUNTY 1106 Cherry Hill Rd. Apt. K. | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) 25-32 | | D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME GAINES | | 14. MOTHER'S MAIDEN NAME Beverly J. Cooper | | ADDRESS 1106 Cherry Hill Rd. Apt. C | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT | | ADDRESS |
| 18. I 776 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH Hydrocephalus | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | PREMATURITY | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-26 1966 to Jan. 31 1967, that (I) (we) last saw the deceased alive on 12-31 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Aleyde A. Melocoton | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Jan. 31-67 | |
| 23C. PHYSICIAN'S NAME (Type) ALEYDE A. MELOCOTON | | M.D. 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 2-28-67 | | 24C. NAME OF CEMETERY or CREMATORY | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robert E. Fox | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

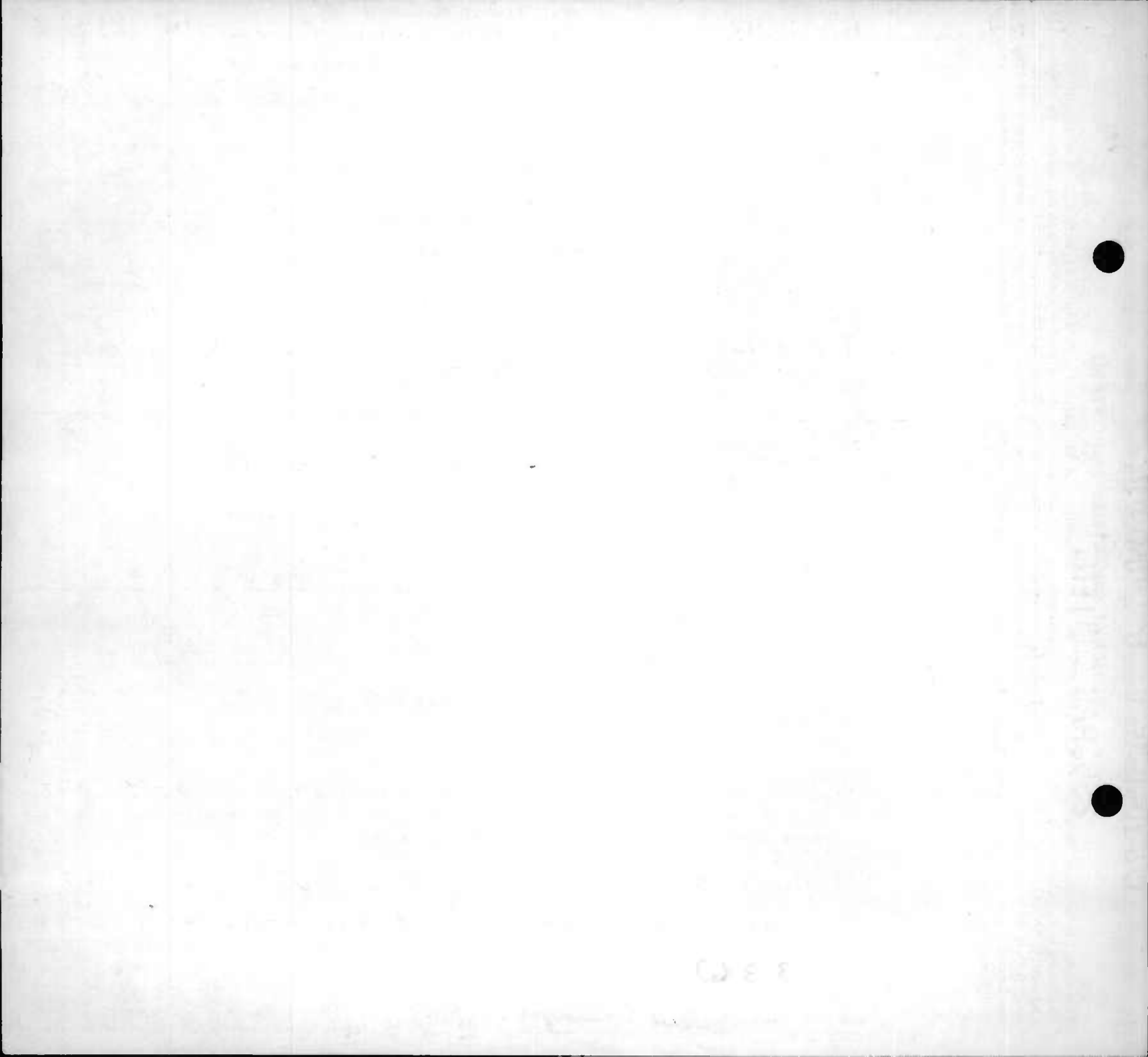
| | | | | | |
|---|---------|--|--------------------------|--|-----------------------------|
| 67-03977 67 2196 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 67 2196 4 | |
| BIRTH NO. | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | Dorsey, Baby Boy | | 2/27/67 10:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 42 Sinai Hospital | | Yond | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 2221 Whittier Ave. (17) | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| MALE | NEGRO | | 2/27/67 | | 1 20 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Unknown | | | Gertrude Dorsey | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 776X I | | Immaturity - 7/5 yrs | | | |
| ANTECEDENT CAUSES | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 2/27 1967 to 2/27 1967, that (1) (we) lost saw the deceased alive on 2/27 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| James Sobel | | | | 2/27/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| James Sobel | | Sinai Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| | | 2-3-67 | | JOHNS HOPKINS MEDICAL SCHOOL | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 6 1967 | | Robert E. Entenman | | MORTUARY SERVICE - BCHD | |

W.F.S

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

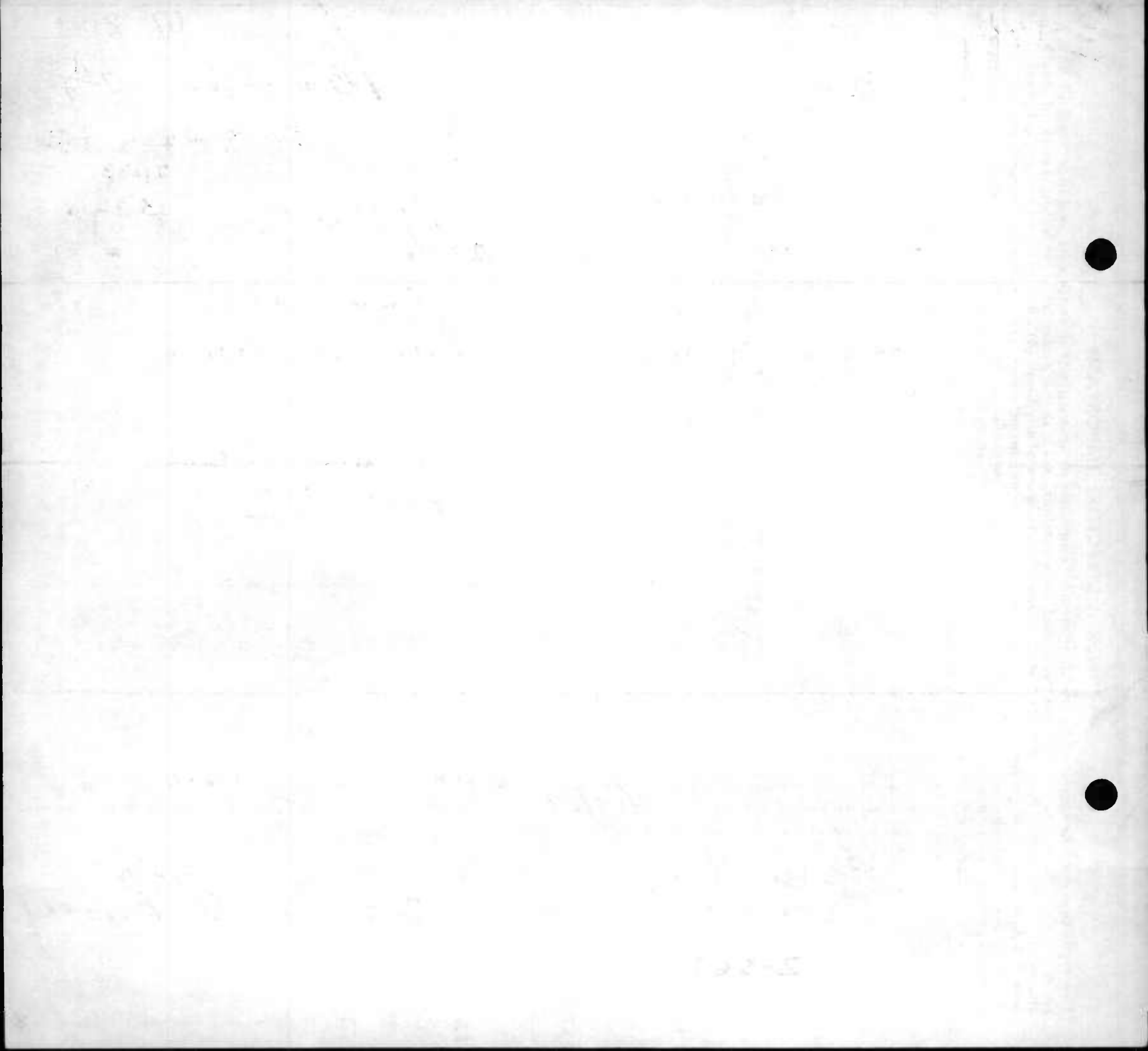
| | | | |
|---|------------------|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2197 | |
| BIRTH NO. 67-01425 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. 67 2197 | | 2. DATE AND HOUR OF DEATH 2-7-67 1:15 PM M. | |
| 1. NAME OF DECEASED (Type or Print) LYTLE Baby Girl | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21218 27-09 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI Hospital of BALTIMORE | | D. STREET ADDRESS (If rural, give location) 1657 E. Coldspring Lane | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 1-20-67 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 4 days |
| 11. BIRTHPLACE (State or foreign country) BALTO. Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Wm. J. Lytle | | 14. MOTHER'S MAIDEN NAME Barbara Wynder | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
| 18. 773.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Respiratory Distress | | INTERVAL BETWEEN ONSET AND DEATH 19 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Immaturity | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-20-1967 to 2-7-1967 , that (I) (we) last saw the deceased alive on 2-7-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Lucile A. Torres M.D. | | 23B. DATE SIGNED 2-7-67 | |
| 23C. PHYSICIAN'S NAME (Type) Lucile A. Torres M.D. | | 23D. ADDRESS SINAI Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 3-3-67 | | 24B. DATE | |
| 24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD | | 24D. LOCATION (City, town, or place only) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. March 6 1967 | | 25B. NAME OF REGISTRAR John E. Jackson | |
| 25C. FUNERAL DIRECTOR ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 2198 | |
|--|---|--|--|---|----------------------------|--|--|
| BIRTH NO. 67 2198 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Baby Girl Shipley | | 2. DATE AND HOUR OF DEATH 7:15 AM 2/23/67 7:15 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hosp. Balt Md. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore Co. | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Randallstown 21133 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) Wilmar Ave., 53-00 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) newborn | 8. DATE OF BIRTH 2/23/67 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. 31 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Harrison M Shipley Jr. | | | | 14. MOTHER'S MAIDEN NAME Patricia Barnes | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/> | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 762.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Prematurity - atelctasis wt 760 gm - 26 weeks pregnant (B) (C) INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from birth 19 to death 19 2/23/67 that (I) (we) last saw the deceased alive on 2/23/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Erwin Hecker | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 2/23/67 | |
| 23C. PHYSICIAN'S NAME (Type) ERWIN Hecker | | | | 23D. ADDRESS 2 E Read St. Baltimore Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 2-3-67 | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR R. E. Feltz | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | | ADDRESS | |



C-235

| | | | |
|---|--|--|--|
| 1. NAME OF DECEASED (Type or Print) JAMES CHESTNUT | | 2. DATE AND HOUR PRONOUNCED DEAD February 15, 1967 7:30 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland NORTH CAROLINA C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore MT. TAVER D. STREET ADDRESS (If rural, give location) Moutavern North Car V-30 | |
| 5. SEX Male | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 9. AGE (In years last birthday) 53 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. CAUSE OF DEATH 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | 23B. DATE 2-28-67 | 23C. NAME OF CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) ANATOMY BOARD OF MARYLAND |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | 24B. NAME OF REGISTRAR Robert E. Farkema | 24C. FUNERAL DIRECTOR ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | |

12-25-5

1
6-532

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 2200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2200

M.E. CASE NO.

| | | | | | |
|---|---------------------------|--|---|---|-----------------------|
| 1. NAME OF DECEASED (Type or Print) Willie Lindsey | | | 2. DATE AND HOUR PRONOUNCED DEAD 2/13/67 9:28 a. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 21-02 D. STREET ADDRESS (If rural, give location) 1447 W. Hamburg St. | | |
| 5. SEX male | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH 62? | 9. AGE (In years last birthday) 62? | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |

| | | | | | | |
|--|---|--|--|--|-------------------------------|----------------------------------|
| MEDICAL CERTIFICATION | 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443 X1 Hypertensive cardiovascular disease (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| | 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | |
| | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| | 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| | ACTUAL SIGNATURE Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 2/14/67 | |
| | EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | 23A. BURIAL CREMATION, REMOVAL (Specify) | 23B. DATE 2-28-67 | 23C. NAME OF CEMETERY or CREMATORY | 23D. LOCATION (City, town, or county) (State) | | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | 24B. NAME OF REGISTRAR Robert E. Farley | 24C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | | ADDRESS | | |

5-28-5

IW

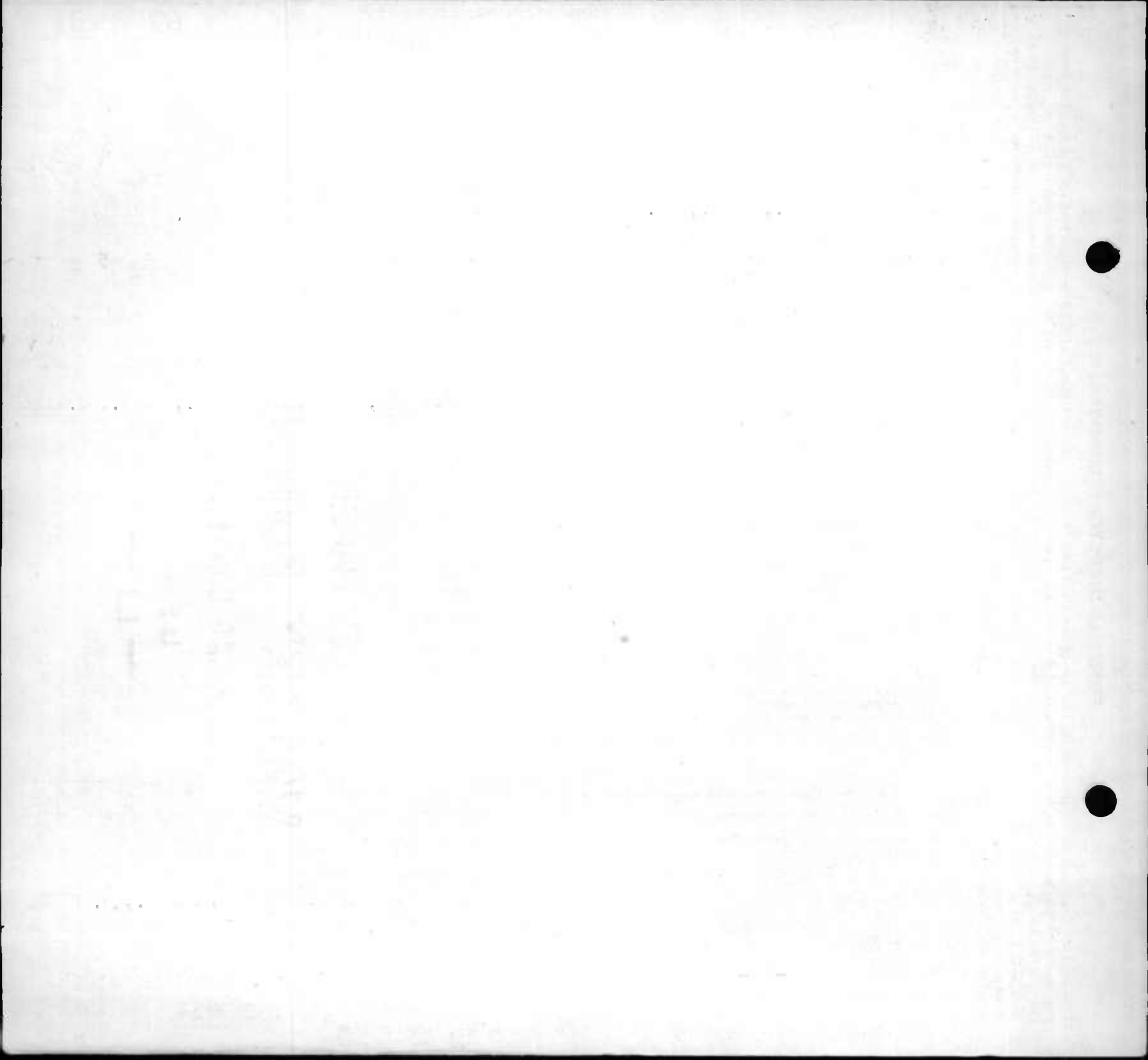
CERTIFICATE OF DEATH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

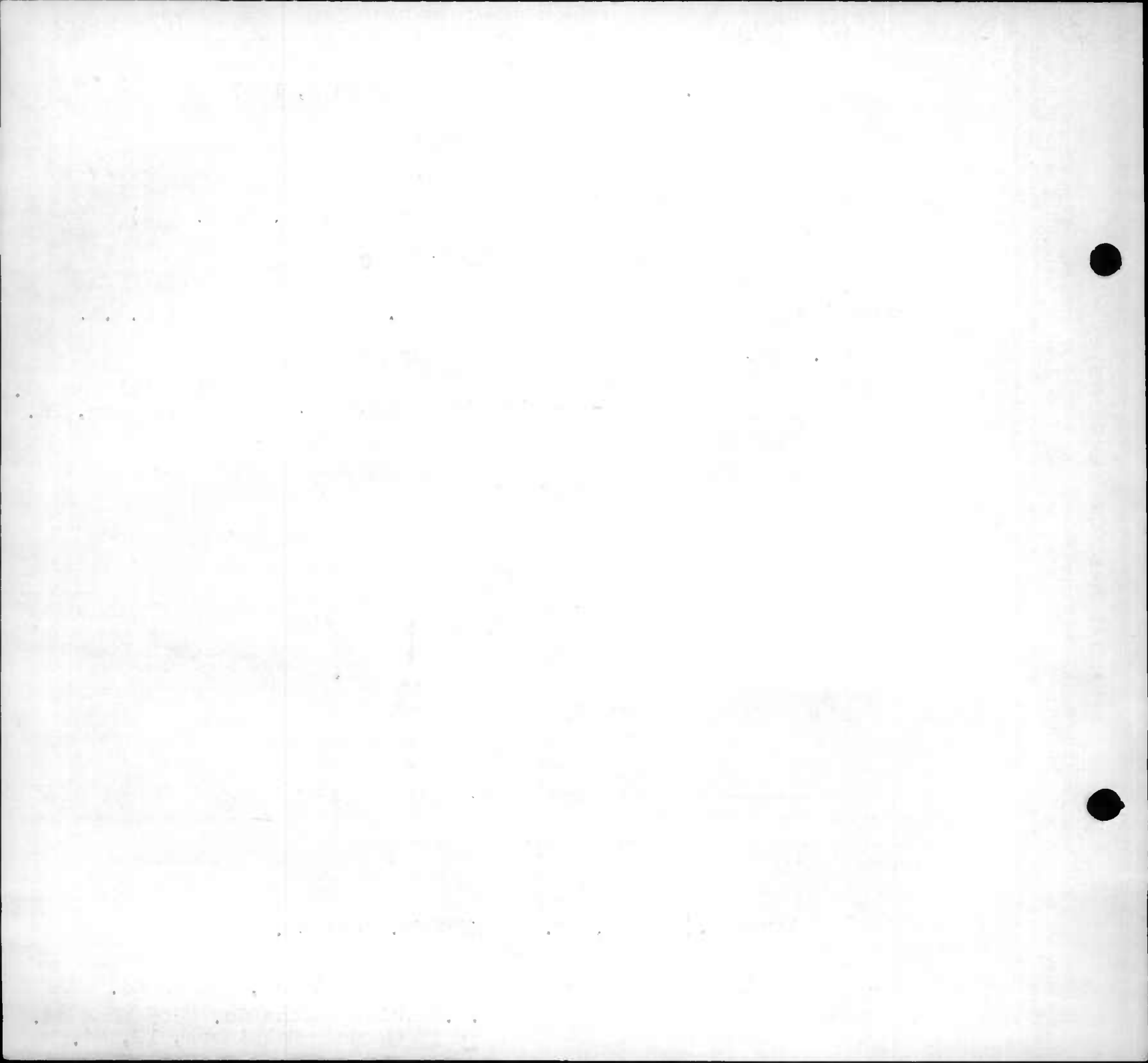
| | | | |
|---|------------------|---|--|
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) ATKINSON, Baby boy of Carolyn | | Feb. 24 1967 1 8 ³⁰ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Ave., Balto., Md. 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1008 Mosher Street 21217 | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 2/23/67 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 1 10. Under 1 Yr. Months Days 1 5 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME Henderson, Carolyn | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | ADDRESS RECORDS; BCH, 4940 Eastern Ave., Balto., Md. 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 773.51 PREMATURITY ANTECEDENT CAUSES Respiratory distress syndrome 29 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 29 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/23 19 67 to 2/24 19 67, that (I) (we) lost saw the deceased alive on 2/24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Vadakan | | 23B. DATE SIGNED 2/24/67 | |
| 23C. PHYSICIAN'S NAME (Type) VIBUL VICHIT-VADAKAN | | 23D. ADDRESS 4940 Eastern Avenue, Balto., Md. 21224 Baltimore City Hospitals | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 2-28-67 | |
| 24C. NAME of CEMETERY or CREMATORY Baltimore City Hospital | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | |
| HOSPITAL DISPOSAL | | | |

HOSPITAL DISPOSAL



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

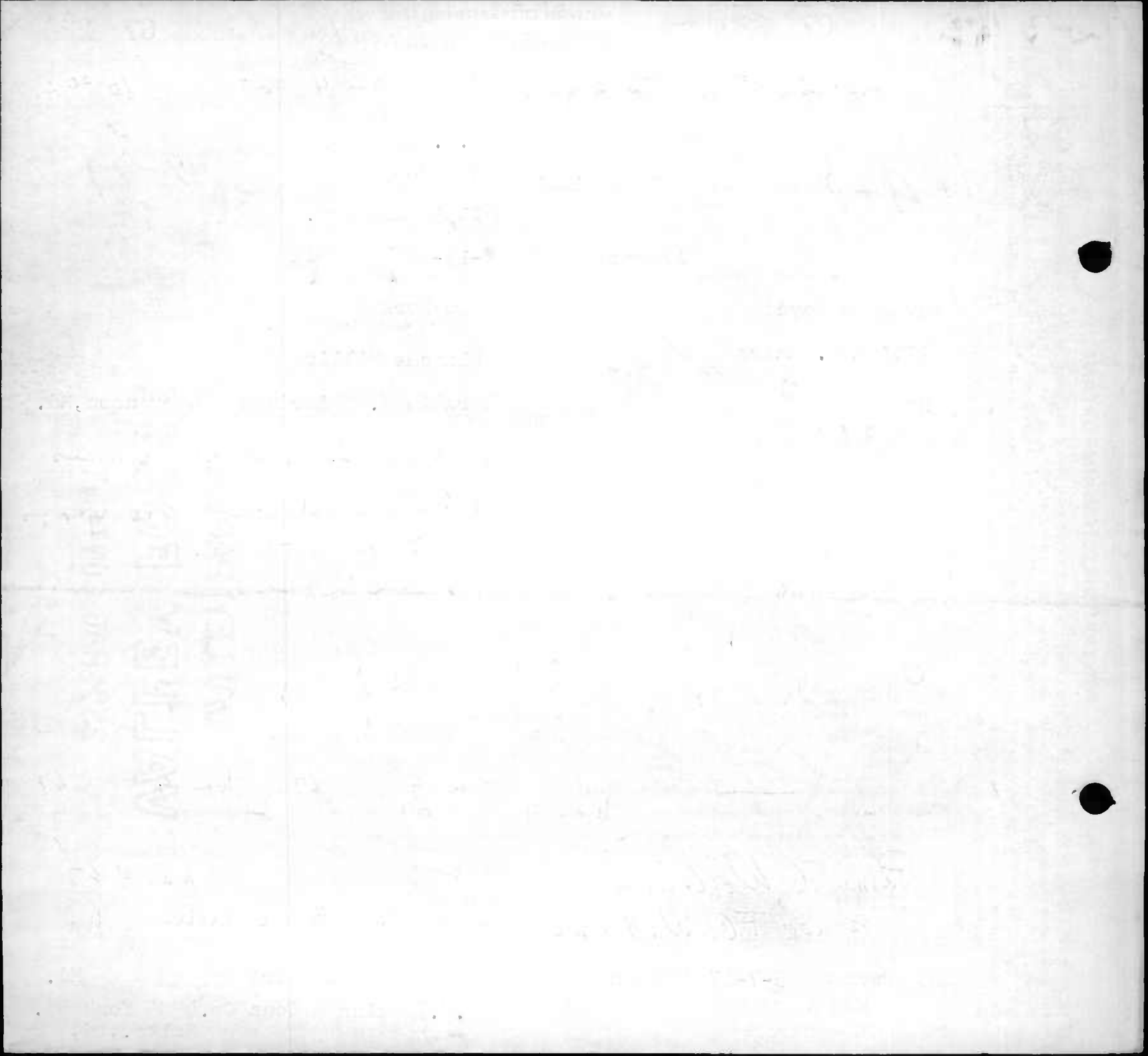
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2202 | |
|---|--------------|---|--|---|--|
| BIRTH NO. 67 2202 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Edith G. Bliss | | March 2, 1967 2 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Washington Apartments | | | A. STATE Maryland | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) Washington Apts. (Apt. 5 D) | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 10/26/1870 | 9. AGE (In years lost birthday) 96 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State - foreign country) Pa. | |
| 13. FATHER'S NAME Harry F. West | | 14. MOTHER'S MAIDEN NAME Fanny McDowell | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-44-3927 | | 17. INFORMANT Miss Eleanor A. Bliss | |
| | | | | ADDRESS 310 Millbank Rd. Bryn Mawr, Pa. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <i>Arteriosclerotic cardiovascular disease.</i> (B) (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes mellitus</i> | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (the hospital) attended the deceased from <i>6-14</i> 19 <i>58</i> to <i>3-2</i> 19 <i>67</i> . that (I) (we) last saw the deceased alive on <i>2-26</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Alfred G. Ossman, Jr.</i> | | | | 23B. DATE SIGNED <i>3-3-67</i> | |
| 23C. PHYSICIAN'S NAME (Type) Alfred G. Ossman, Jr. M.D. | | | | 23D. ADDRESS 1010 St. Paul St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE <i>2/4/1967</i> | 24C. NAME of CEMETERY or CREMATORY Greenmount | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 6 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i> | | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore, 12, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

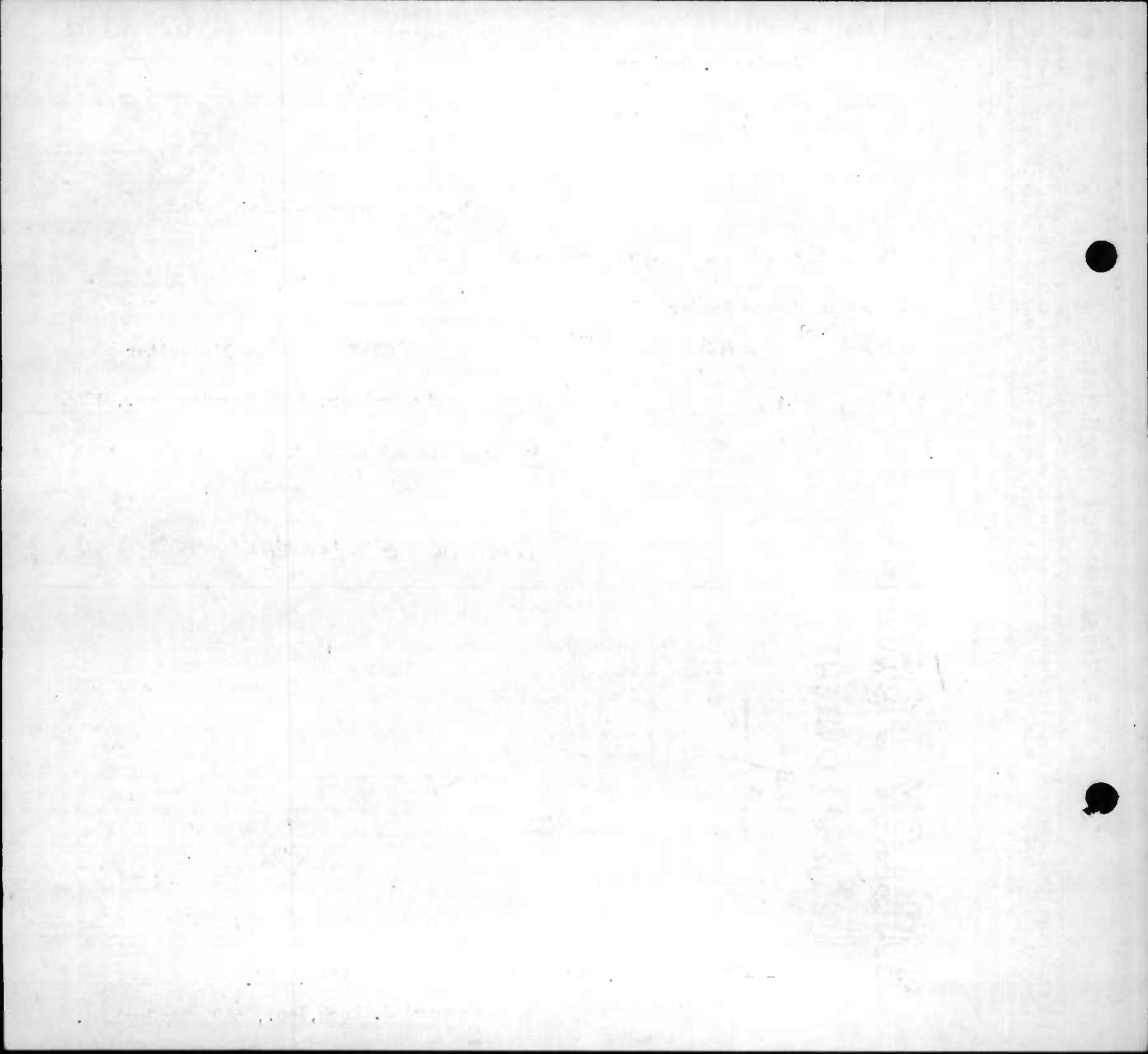
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2203 | |
|--|---------------------|---|--------------------------------------|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 2203 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Matilda E. Whitridge</i> | | 2. DATE AND HOUR OF DEATH <i>Mar 4. 67 10 20 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>44 Union Memorial Hospital</i> | | A. STATE <i>N.Y.</i> B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>New York</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>1155 Park Ave.</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Divorced</i> | 8. DATE OF BIRTH <i>8-13-1884</i> | 9. AGE (In years last birthday) <i>82</i> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Never Employed</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>New York</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | |
| 13. FATHER'S NAME <i>William H. Emory</i> | | 14. MOTHER'S MAIDEN NAME <i>Blanche Willis</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Horatio H. Whitridge Stevenson, Md.</i> | |
| 18. <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO <i>Cerebral Hemorrhage</i> (B) DUE TO <i>Arterio-sclerosis</i> (C) DUE TO <i>2 hypertension</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> <i>10 years</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Mar 4</i> 19 <i>67</i> to <i>Mar 4</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Mar 4</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Palmer F.C. Williams</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>Mar 4. 67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Palmer F.C. Williams</i> | | 23D. ADDRESS <i>Livon Rd. Bump Mills, Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Entombment</i> | | 24B. DATE <i>3-7-67</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Greenmount</i> | |
| 24D. LOCATION (City, town, or county) <i>Baltimore</i> | | 24E. (State) <i>Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 6 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Talbot</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|--|--|------------------------|--|--|---|------------------------------------|--|--|--|---|--|--------------------------------|--|--|--|--|--|--|--|
| 67 2204 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 2204 | | | | | | | | | |
| BIRTH NO. | | | | | | | | | | M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) CHARLES P. GRABNER | | | | | | | | | | 2. DATE AND HOUR OF DEATH 3/4/67 4:15 AM | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND MARYLAND GENERAL HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE, MARYLAND 48 | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21206 26-01 D. STREET ADDRESS (If rural, give location) 5606 MAYVIEW AVE | | | | | | | | | |
| 5. SEX M | | 6. RACE Cauc | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) YES - MARRIED | | 8. DATE OF BIRTH 1/27/96 | | 9. AGE (In years lost birthday) 71 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Motor Tender | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) OREGON | | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME XXXXXXXXXX Carl GRABNER (Grabner) | | | | | 14. MOTHER'S MAIDEN NAME XXXXXXXXXX ? Amelia Walter | | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW1 | | | | | 16. SOCIAL SECURITY NO. 216-01-1032A | | | | |
| 17. INFORMANT Hedwig Grabner, 5606 Mayview Ave., 21206 | | | | | | | | | | ADDRESS | | | | | | | | | |
| 18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHITIS CA LONG - 8 MONTHS | | | | | | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. TRACHEAL & ESOPHAGEAL OBST. - 1 MONTH | | | | | | | | | | (A) DUE TO | | | | | (B) DUE TO | | | | |
| (C) DUE TO | | | | | | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2-2-67 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACHEOSTOMY FOR RESP. DISTRESS | | | | | 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore-City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 3-4-67 | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (H) (this hospital) attended the deceased from 2-3-67 19 to 3-4-67 19, that (H) (we) last saw the deceased alive on 3-4-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Robert M. Beazley | | | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED 3/4/67 | | | | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT M. BEAZLEY | | | | | | | | | | M.D. 23D. ADDRESS MARYLAND GENL HOSPITAL | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 3-8-67 | | | | | 24C. NAME OF CEMETERY or CREMATORY Balto. National | | | | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | | | 25B. NAME OF REGISTRAR P. J. E. F. F. | | | | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., 5305 Harford Rd. | | | | | ADDRESS | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2205 | |
|--|-----------|---|--------------------------|--|---------------------------------|
| <div style="display: flex; justify-content: space-between;"> B-614 67 2205 CERTIFICATE OF DEATH </div> | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| LEON WELDON BROWNLEY | | MARCH 5, 1967 1 40 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| US PUBLIC HEALTH SERVICE HOSPITAL 3100 WYMAN PARK DRIVE | | MD. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4609 CROSSWOOD AVE. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| MALE | CAUCASIAN | MARRIED | SEPT. 17, 1904 | 62 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| CHIEF MATE | | SEAMAN | | VIRGINIA | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| SAMUEL BROWNLEY | | | MARY V. GAY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 081-12-7268 | | RECORDS USPHS HOSPITAL, BALT., MD. | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) CARDIAL ARREST DUE TO (B) PULMORY EMBOLUS DUE TO 30 minutes (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| SQUAMOUS CELL CARCINOMA OF SKIN METASTATIC TO LEFT INGUINAL 2 YEARS NODES | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 3/2/67 | | SEE II ABOVE | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from FEB. 26 19 67 to MARCH 5 19 67, that (we) last saw the deceased alive on MARCH 5 19 67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Carl S. Jefferis, Jr. | | | | 23B. DATE SIGNED 3/5/67 | |
| 23C. PHYSICIAN'S NAME (Type) EARL S. JEFFERIS, JR. | | | | 23D. ADDRESS US PHS HOSPITAL, BALT. MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3/8/67 | | Matthews Chapel Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 6 1967 | | Robert E. Taylor | | Leonard J. Ruck Inc. 5305 Harford Rd. #14 | |

WITNESS POLICE

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2206 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2206 | |
|---|-------------------------|---|---|--|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Sadie J. Nottingham</i> | | | | 2. DATE AND HOUR OF DEATH <i>March 5, 1967</i> <i>3:40 P.</i> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>00</i> <i>2828 N. Calvert Street</i> | | | | A. STATE <i>Md.</i> B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <i>12-03</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>2828 N. Calvert Street</i> | | | |
| 5. SEX <i>female</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i> | 8. DATE OF BIRTH <i>9-26-1898</i> | 9. AGE (In years lost birthday) <i>68</i> | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>Thomas J. Henderson</i> | | | 14. MOTHER'S MAIDEN NAME <i>Lela Carey</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>215265357</i> | | 17. INFORMANT ADDRESS <i>Donald B. Nottingham -- Same</i> | | |
| 18. <i>422.17-153.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>Cardio-Vascular Disease</i> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <i>Possible Carcinoma of Intestines</i> | | <i>?</i> | |
| 19A. DATE OF OPERATION <i>0 None</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan. 3, 1967</i> to <i>March 5, 1967</i> , that (I) (we) last saw the deceased alive on <i>March 6, 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Frank N. Ogden</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>March 6, 67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>FRANK N. OGDEN</i> | | | | 23D. ADDRESS M.D. <i>2701 N. Calvert St</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i> | | 24B. DATE <i>3/8/67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Salem Methodist Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Pocomoke City, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 6 1967</i> | | 25B. NAME OF REGISTRAR <i>R. E. Johnson</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Leonard J. Ruck Inc Baltimore, Md.</i> | | | |

1
C-200

67 2207

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2207

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Morris T. Cage, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

3/5/67 12:10 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4109 St. Georges Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

Feb. 20, 1928

9. AGE (In years
last birthday)

39

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

School Teacher

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Texas

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Morris T. Cage, Sr.

14. MOTHER'S MAIDEN NAME

Lillie Dale

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes 1953-1955

16. SOCIAL
SECURITY NO.

464421315

17. INFORMANT

ADDRESS

William Bowen 2706 Louise Ave. Balto.

18. E 819.41

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Multiple injuries
DUE TO

II
ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Alameda near Argonne Dr.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

3 4 67 11:59p.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

driver of auto into fixed object

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/5/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

burial

23B. DATE

3-9-67

23C. NAME OF CEMETERY or CREMATORY

Robstown Cemetery

23D. LOCATION

(City, town, or county)

Robstown, Texas

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 6 1967

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc Baltimore, Md.

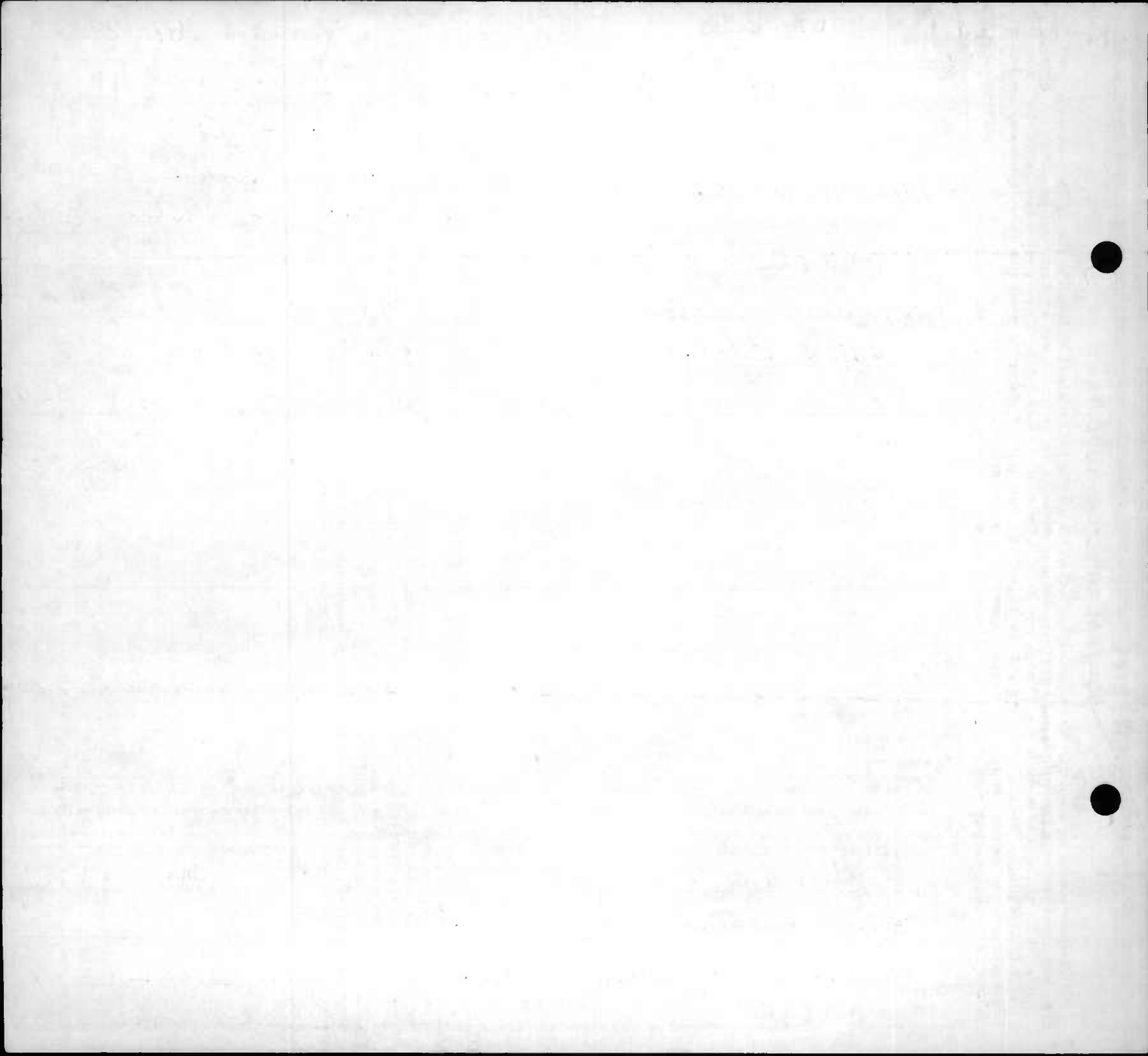
ADDRESS

Wm. L. Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

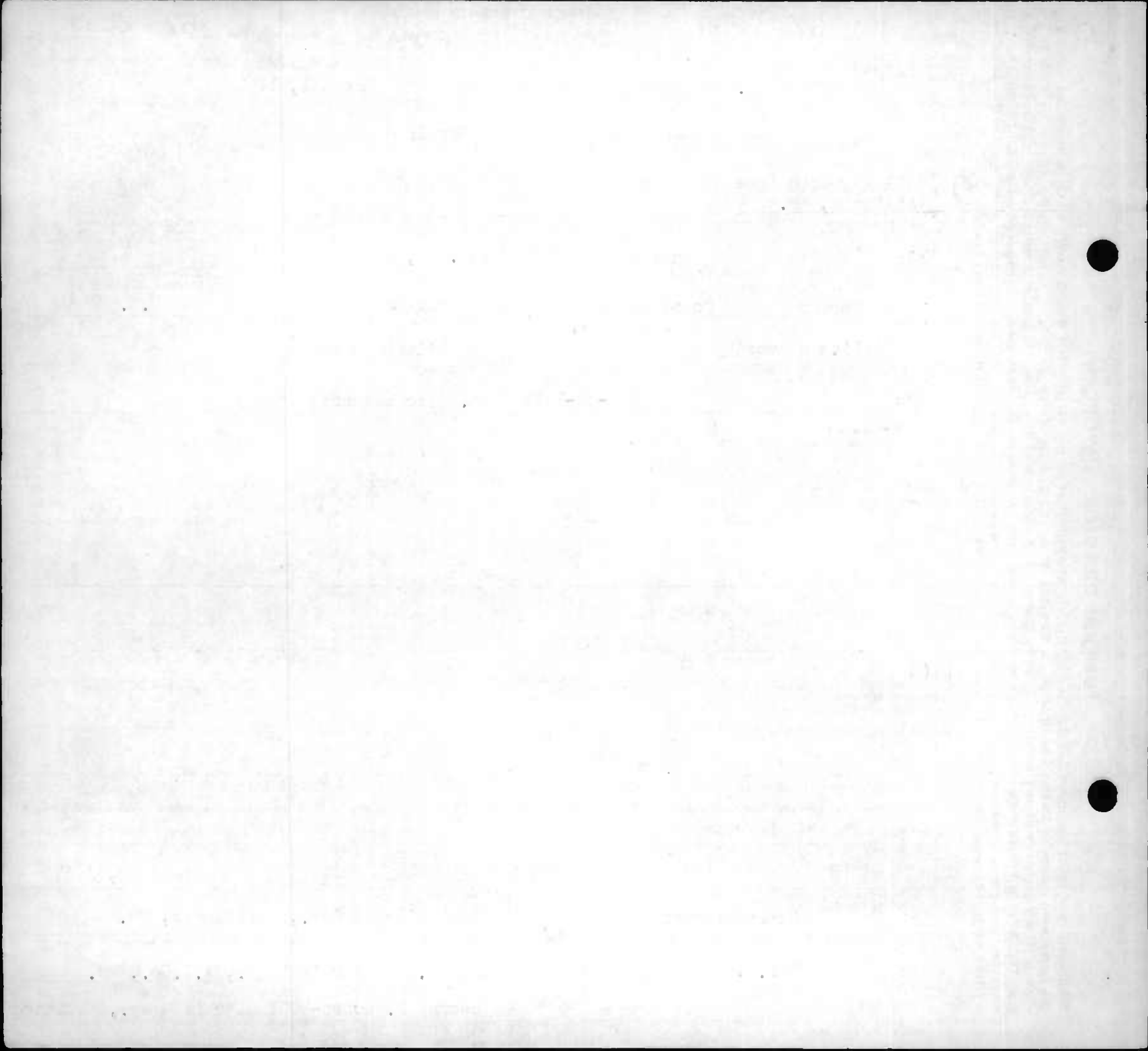
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|---|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2208 | | | | |
| BIRTH NO. 67 2208 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) BERTHA V. KELBAUGH | | | | | 2. DATE AND HOUR OF DEATH 3-1-67 11 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY A.A.B. | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 091142 ROJAND HEIGHTS | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) SEVERNA PARK 52-00 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) RD 2 Box 576 Whitney Land | | | | |
| 5. SEX FEM. | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH 4-3-01 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WORKER | | | 10B. KIND OF BUSINESS OR INDUSTRY Cotton Mill | | 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME AMOS BARNES | | | 14. MOTHER'S MAIDEN NAME IDA GORE | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 705102290D | | 17. INFORMANT ADDRESS Mrs. Dorothy Parker ABOVE | | | | |
| 18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma Lung (B) 3 month (C) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 1966 to March 1 1967 , that (I) (we) last saw the deceased alive on 3/1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Sheldon Goldgeier M.D. | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED March 3, 1967 | | |
| 23C. PHYSICIAN'S NAME (Type) SHELDON GOLDGEIER M.D. | | | | | 23D. ADDRESS 848 W 36th Street | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | | 24B. DATE Burial 3-4-67 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven | | 24D. LOCATION (City, town, or county) (State) Glen Burnie Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR Robert E. Tolson | | 25C. FUNERAL DIRECTOR Robert S. Barranco | | ADDRESS Severna Pk | | | |



FUNERAL DIRECTOR: IMPORTANT

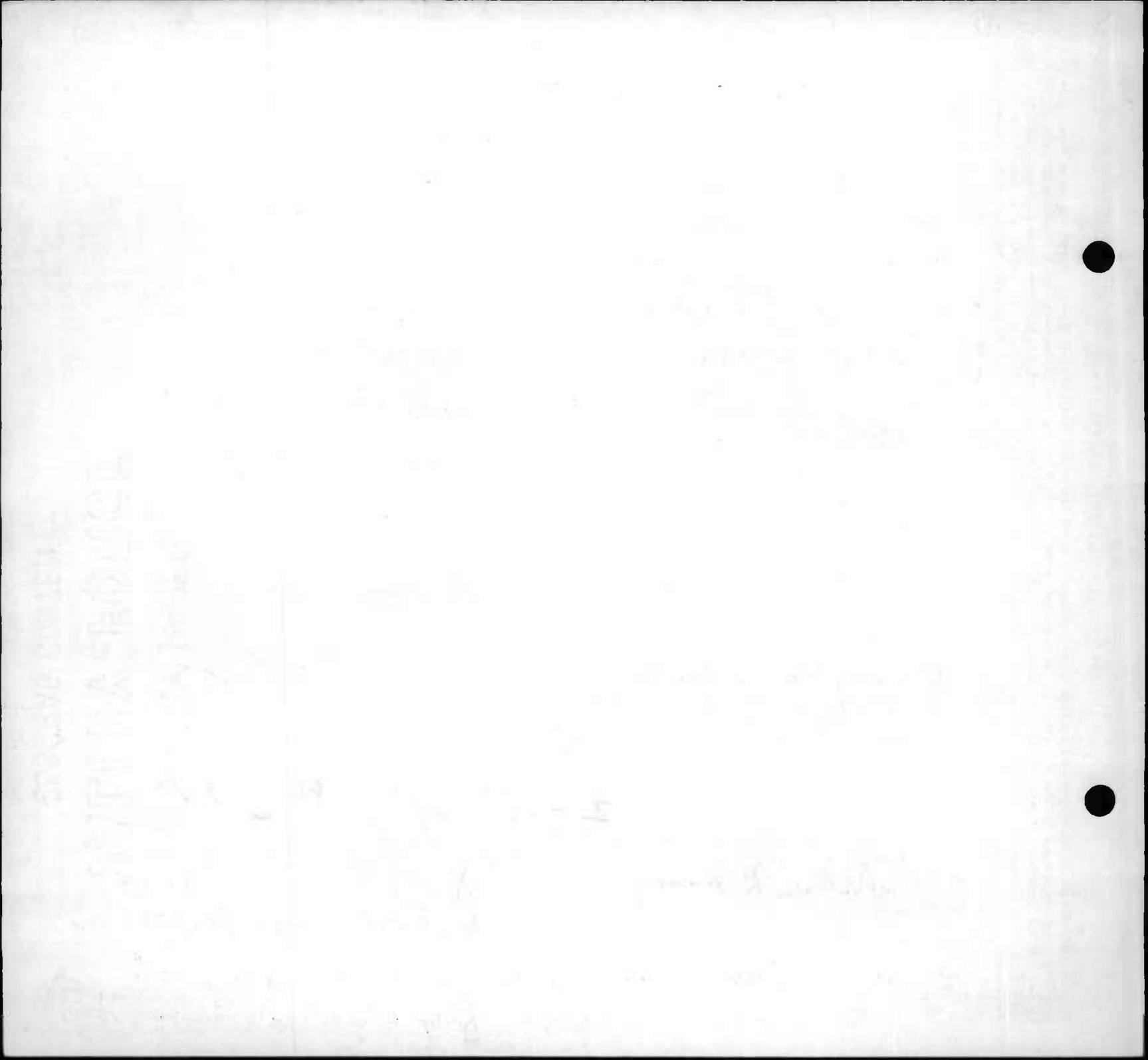
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2209 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 67 2209 | |
|--|-------------------------|---|--|---|---|
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JOSEPH E. WEGWORTH | | 2. DATE AND HOUR OF DEATH March 1, 1967 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION 2501 Wegworth Lane Baltimore, Md. | | D. STREET ADDRESS (If rural, give location) 2501 Wegworth Lane | | 25-42 | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH Nov. 15, 1891 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metal Worker | | 10B. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME William Wegworth | | 14. MOTHER'S MAIDEN NAME Elizabeth Smith | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-16-7819 | | 17. INFORMANT ADDRESS Mrs. Rose Wegworth (same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 420.1 I | | CAUSE OF DEATH (A) DUE TO ACUTE CORONARY OCCLUSION WITH infarction of myocardium (B) DUE TO Generalized arteriosclerosis (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH minutes months | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from October 16, 1966 to March 1, 1967 , that (I) (we) last saw the deceased alive on Feb. 26, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Henry Armanas | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED March 2, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) Henry Armanas | | 23D. ADDRESS M.D. 1934 Wilkens Ave., Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Mar. 4, 1967 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Pk. | |
| 24D. LOCATION (City, town, or county) (State) Ritchie Hgwy., A.A.Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Talley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS George J. Gonce-4001 Ritchie Hgwy., Baltimore | | | |



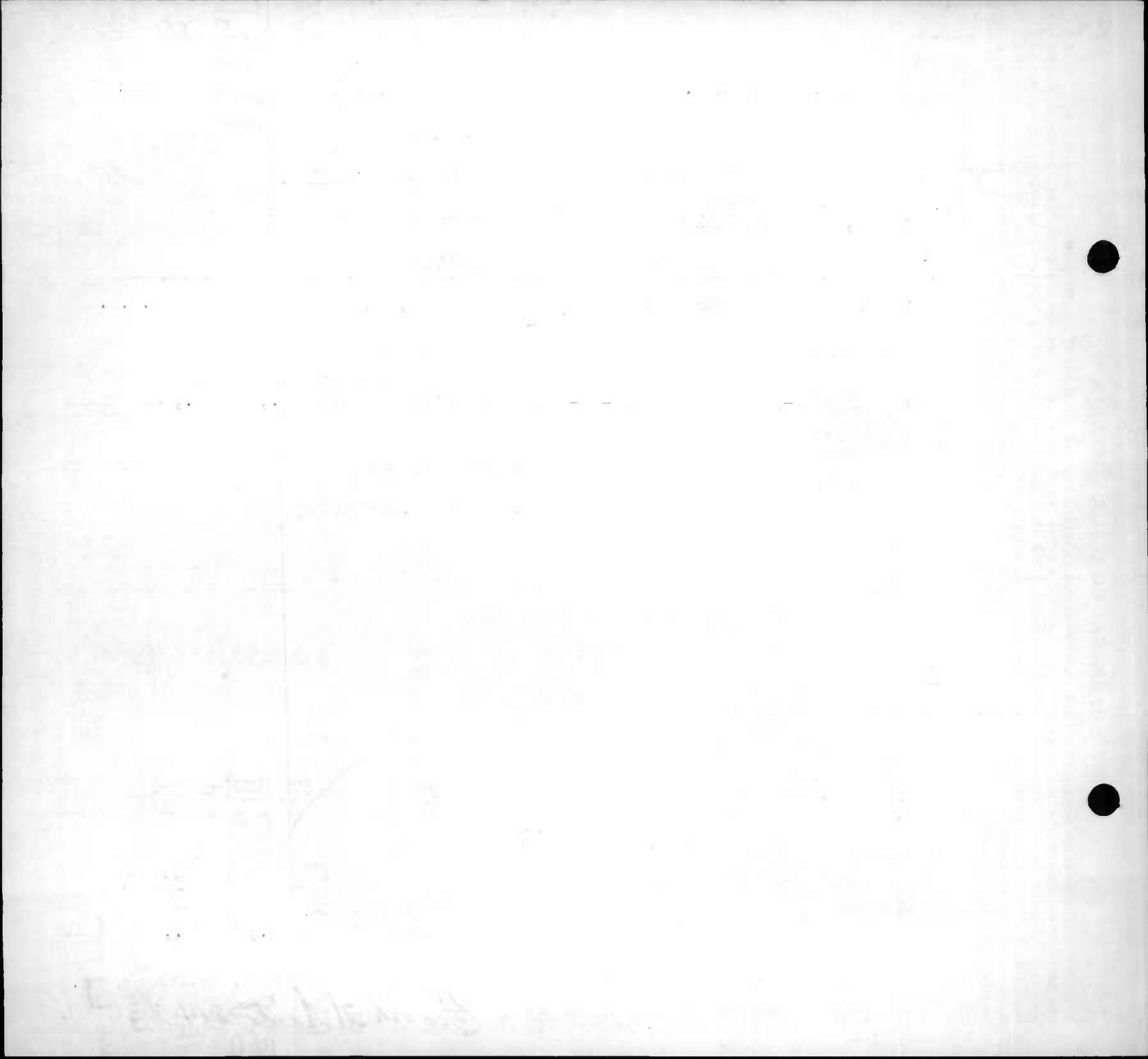
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------|--|------------------|--|---|
| 67 2210 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2210 | |
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| William J SHIMEK | | March 1, 1967 | | 8 a M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| 00 3222 Belair Road | | Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | 8-01 | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 3222 Belair Road | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Male | White | Unmarried | Jan. 7, 1899 | 68 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Asst. Supt. | | Balt Gas & Elec Co | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| JAMES SHIMEK | | FRANCES - | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 212 05 74684 | | Elizabeth M. Shimek 3222 Belair Road | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 159 X 1 | | (A) Ceraroma Soolo Interloof | | 1 1/2 yrs | |
| ANTECEDENT CAUSES | | (B) Malnutrition | | 6 mos | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 January 1966 | | Exploratory | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | Cancer | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 15 1966 to 3-1 1967, that (I) (we) last saw the deceased alive on 2-26 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| William L. Deary | | | | 3-3-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | M.D. 3025 Belair Road Balt 13 Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3/4/67 | | Genders of Faith Cemetery | |
| | | | | Baltimore, Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 6 1967 | | Robert E. Taylor | | Philip F. Gach 1211 Choseco Ave. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

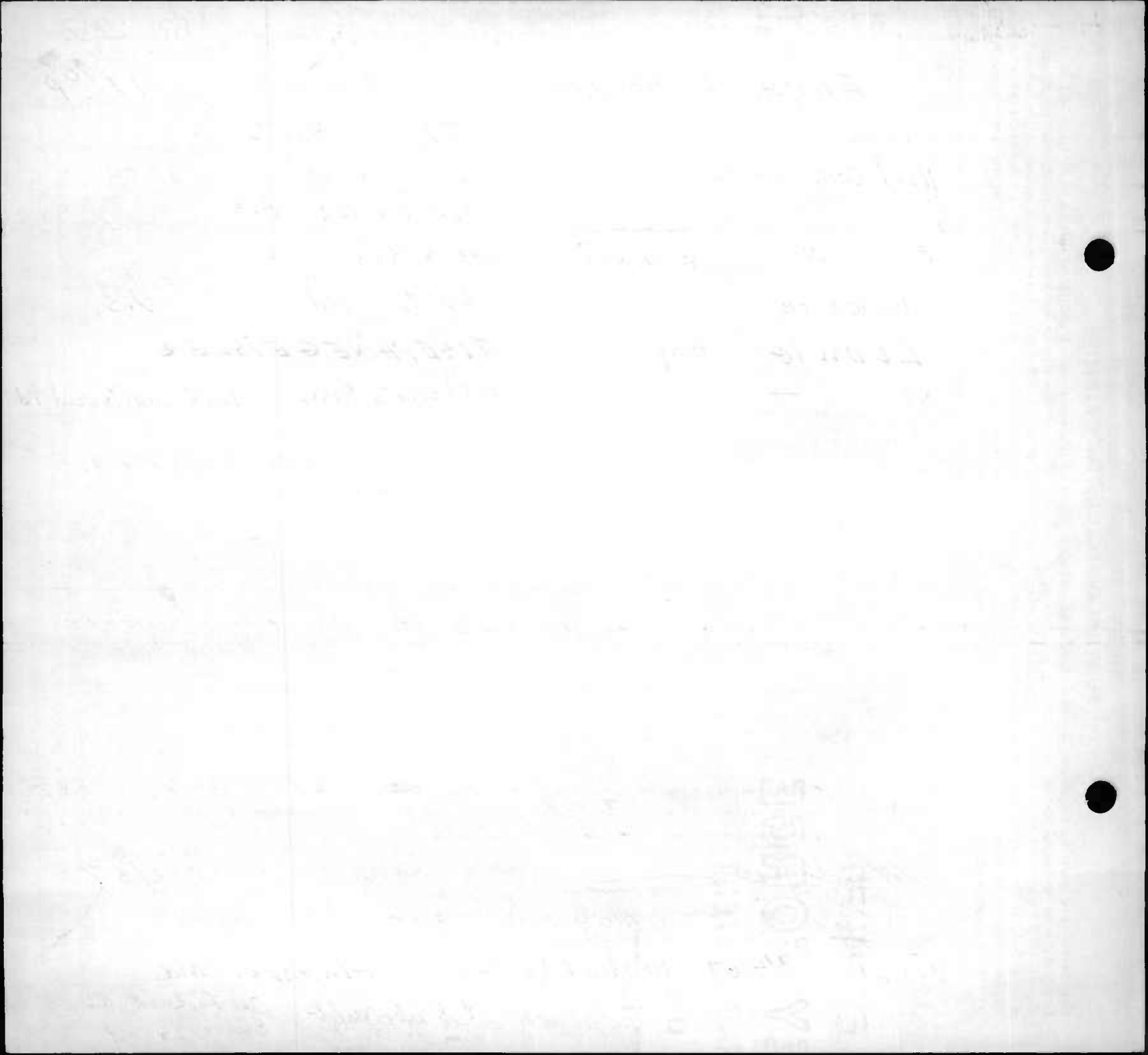
| | | | |
|--|---|---|---|
| <div style="display: flex; justify-content: space-between;"> R-600 67 2211 </div> <div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH Registered No. 67 2211 </div> | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ROYER, Herschel G. | | 2. DATE AND HOUR OF DEATH 3/3/67 12:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21211 D. STREET ADDRESS (If rural, give location) 3017 Chestnut Avenue | |
| 5. SEX Male 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 5/10/98 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10B. KIND OF BUSINESS OR INDUSTRY Crown Bork & Seal Co | |
| 11. BIRTHPLACE (State or foreign country) Baraboo, Wisconsin | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James Royer | | 14. MOTHER'S MAIDEN NAME Ida Andrus | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) Yes 3/5/18-3/9/22 | | 16. SOCIAL SECURITY NO. 212-09-8053 | |
| 17. INFORMANT V A Hospital Records ADDRESS 3900 Loch Raven Blvd., Balto., Md 21218 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic Emphysema (A) DUE TO Respiratory Insufficiency (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH greater than 10 yr | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 7th 19 67 to March 3rd 19 67 , that (I) (we) last saw the deceased alive on March 3rd 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Robert R. Kent M.D. | | 23B. DATE SIGNED 3/3/67 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT KENT | | 23D. ADDRESS VA HOSPITAL 3900 Loch Raven Blvd., Balto., Md 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/6/67 | |
| 24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery | | 24D. LOCATION (City, town, or county) (State) Parkville, Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR Frank H. Seitz | |
| 25C. FUNERAL DIRECTOR ADDRESS 814 N 36th St | | | |



FUNERAL DIRECTOR: IMPORTANT

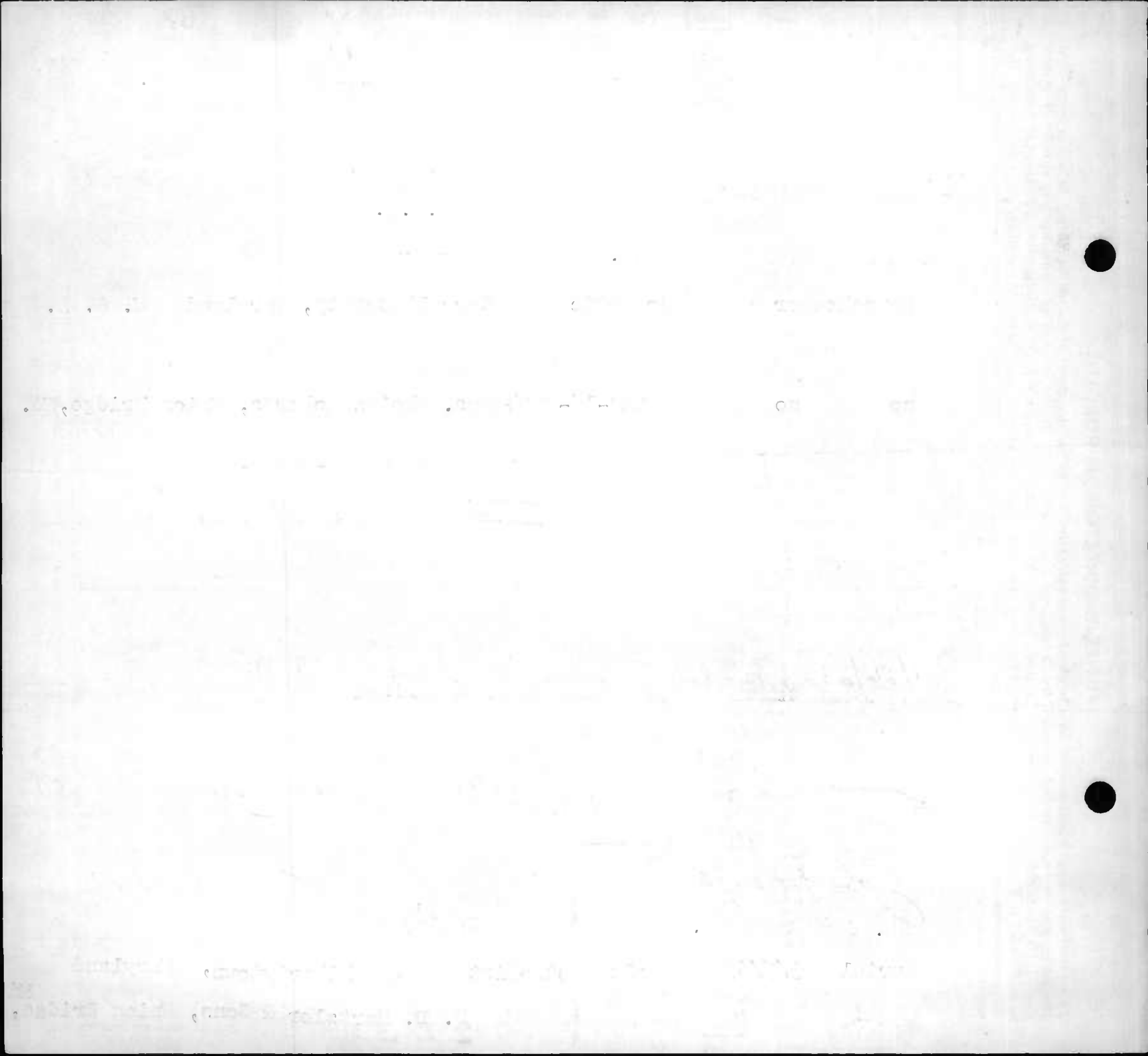
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 2212 | |
|---|--|--|--|--|--|--|--|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> H-6515 67 2212 </div> | | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) EMMA L. HERMAN </div> <div> 2. DATE AND HOUR OF DEATH 3-1-67 11:00 P.M. </div> </div> | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION Hood Conv. Home </div> <div style="flex: 1;"> (If not in hospital or institution, give street address or location) </div> </div> | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex;"> <div style="flex: 1;"> A. STATE MD. </div> <div style="flex: 1;"> B. COUNTY BAIT. Co. </div> </div> | | | | | |
| 5. SEX F | | | | | | 6. RACE W. | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH MAR. 18, 1888 | |
| 9. AGE (In years last birthday) 78 | | | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BAIT. MD. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | 13. FATHER'S NAME LUDWIG GAY | | | | | |
| 14. MOTHER'S MAIDEN NAME JOSEPHINE GEISLER | | | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | | |
| 16. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT M. Elizabeth Russo | | | | | |
| ADDRESS 1065 CRAFTSWOOD RD. | | | | | | | | | | | |
| 18. CAUSE OF DEATH | | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> INTERVAL BETWEEN ONSET AND DEATH 7 1/2 yr. </div> </div> | | | | | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease years. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from 6-23-1965 to 3-1-1967, that (we) last saw the deceased alive on 3-1-1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE John J. Conroy | | | | | | | | M.D. | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) John J. Conroy | | | | | | | | 23D. ADDRESS 5800 Edmonson Ave. | | 23B. DATE SIGNED 3/3/67 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 3/4/67 | | 24C. NAME of CEMETERY or CREMATORY Meadow Ridge Cem | | | | 24D. LOCATION (City, town, or county) (State) HOWARD CO MD | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | | 25B. NAME OF REGISTRAR E. J. MacNally | | | | 25C. FUNERAL DIRECTOR E. J. MacNally | | | |
| | | | | | | | | ADDRESS 301 Frederick Rd Bait. 28. MD | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---------|--|------------------|--|----------------------------------|
| 67 2213 | | CERTIFICATE OF DEATH | | 67 2213 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | GERALDINE ROBERTS. | | 3-1-67 1.30 A | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL | | A. STATE MARYLAND | | B. COUNTY Carroll Co. | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) UNION BRIDGE | | 56-00 | |
| | | D. STREET ADDRESS (If rural, give location) R.F.D. 1 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Days |
| FEMALE | NEGRO | SEP. | 1-12-24 | 43 | 11. If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| housekeeper | | domestic | | Carroll County, Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| HERBERT BUTLER | | THELMA ROBERTS | | U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| no no | | 220-16-0224 | | Mrs. Thelma Roberts, Union Bridge, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Congestive heart failure | | | |
| ANTECEDENT CAUSES | | (B) Rheumatic heart disease | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 1/26/67 | | Formal arteriovenous thrombosis | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/30 1966 to 3/1 1967. | | that (I) (we) last saw the deceased alive on 2/28/67 19 | | and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| DR. JOHN SERGENT. | | 23D. ADDRESS | | 3/1/67 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 3/5/67 | | Wesley Methodist | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAR 6 1967 | | Robert E. Ferguson | | D. D. Hartzler & Sons, Union Bridge, Md | |
| 24D. LOCATION (City, town, or county) | | 24E. LOCATION (State) | | | |
| Libertytown, Maryland | | | | | |

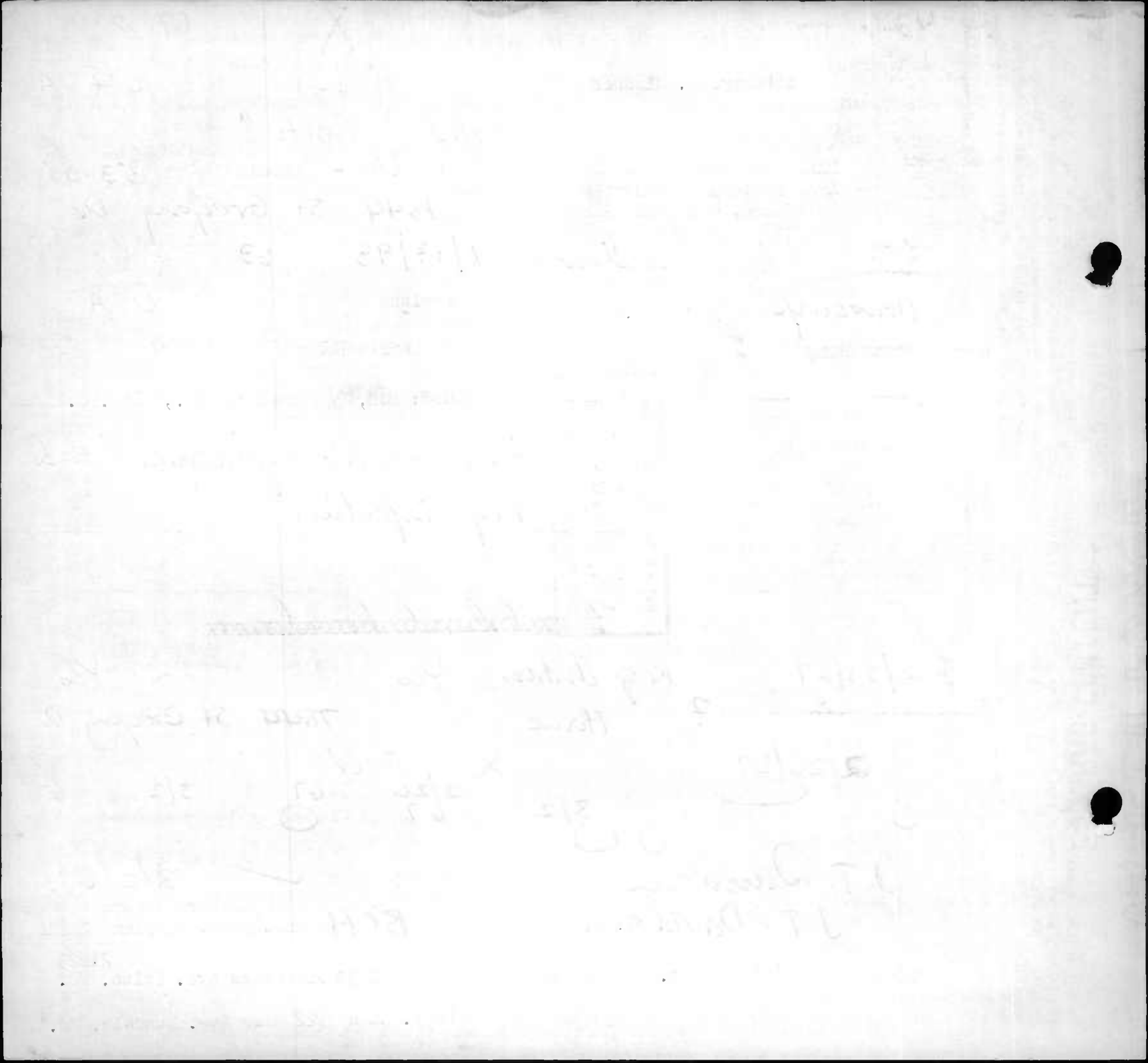


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2214 | |
|---|--------------|--|--------------------------|--|--|
| BIRTH NO. 65-21645 67 2214 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Rhonda L. Koscielski | | 3/4/67 8:05A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital | | Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1522 Elrino Street | | 26-36 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Female | White | Child | 9/2/65 | 1 | |
| 10A. USUAL OCCUPATION (Give kind at work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| NONE | | | | Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | U.S.A. | | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Robert KOSCIELSKI | | | Anna McLaughlin | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | NONE | | Father, Robert Koscielski #4,a,b,c,d | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 180x I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) DUE TO Pseudomonas Septicemia | | 3 days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Small blood infection due to Intussusception | | 10 days | |
| | | (C) Wilms Tumor | | Probably since birth | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 3/22/67 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/9 19 67 to 3/4 19 67 , that (I) (we) last saw the deceased alive on 3/4 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death. | | | | | |
| 23A. SIGNATURE Robert S. Pipkin M.D. | | | | 23B. DATE SIGNED 3/4/67 | |
| 23C. PHYSICIAN'S NAME (Type) Robert Pipkin | | | | 23D. ADDRESS The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3-7-1967 | | Parkwood | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 6 1967 | | R. D. K. E. F. Adams | | JOHN J. DUDA, Dundalk, Md. 21222 | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | | | |
|---|--|------------------|--|--|---|------------------------------|--|--|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
| -426 67 2215 | | | | | 67 2215 | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Katherine M. Glasser | | | | | 2. DATE AND HOUR OF DEATH 3/2/67 10 45 A.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Balto Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto - Dundalk 53-00 D. STREET ADDRESS (If rural, give location) 7844 St. Gregory Dr. | | | | | | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 11/13/98 | | 9. AGE (In years lost birthday) 69 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | |
| 13. FATHER'S NAME Otto Hueg | | | | | 14. MOTHER'S MAIDEN NAME Carrie Beard | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 17. INFORMANT RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224 | | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gram negative septicemia Leg infection ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. XXXXXX | | | | | 19. DATE OF OPERATION 2/27/67 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Resp. distress | |
| 20A. AUTOPSY? (Yes or No) Yes | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ? | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 7844 St. Gregory Dr. | | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 2/26/67 | | | | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? Fell | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/26 19 67 to 3/2 19 67, and that (I) (we) last saw the deceased alive on 3/2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE J. T. Davidson | | | | | 23B. DATE SIGNED 3/2/67 | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) J. T. Davidson | | | | | 23D. ADDRESS BCH 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 3/4/67 | | | | | | |
| 24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | | | | 24D. LOCATION (City, town, or county) 21223 2930 Frederick Ave. Balto. Md. | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | | | | 25B. NAME OF REGISTRAR R. E. Taylor | | | | | | |
| 25C. FUNERAL DIRECTOR John J. Duda | | | | | 25D. ADDRESS 7922 Wise Ave. Dundalk, Md. | | | | | | |



67 2216

BALTIMORE CITY HEALTH DEPARTMENT

67 2216

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Joseph Kusyk

2. DATE AND HOUR PRONOUNCED DEAD

3/1/67 9:00 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 City Hospitals

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore Co.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

53-00

D. STREET ADDRESS (If rural, give location)

8336 Old Philadelphia Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

3-5-07

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

Construction Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Thomas Kusyk

14. MOTHER'S MAIDEN NAME

Anna

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

578-07-6545

17. INFORMANT

Rose M. Kusyk 8336 Philadelphia Rd.

ADDRESS

18. 331X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Massive spontaneous intracerebral hemorrhage
DUE TO

. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/2/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-6-67

23C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

23D. LOCATION (City, town, or county) (State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 6 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Philip E. Grach 124 Chesaco Ave.

ADDRESS

1. The first part of the report is a general description of the project and its objectives. It also includes a brief history of the project and a list of the people involved.

2. The second part of the report is a detailed description of the project's progress. It includes a list of the tasks that have been completed and a list of the tasks that are still pending.

3. The third part of the report is a discussion of the project's results. It includes a list of the findings that have been discovered and a list of the conclusions that have been drawn.

4. The fourth part of the report is a discussion of the project's future. It includes a list of the recommendations that have been made and a list of the actions that need to be taken.

5. The fifth part of the report is a conclusion. It includes a list of the main points that have been made and a list of the conclusions that have been drawn.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

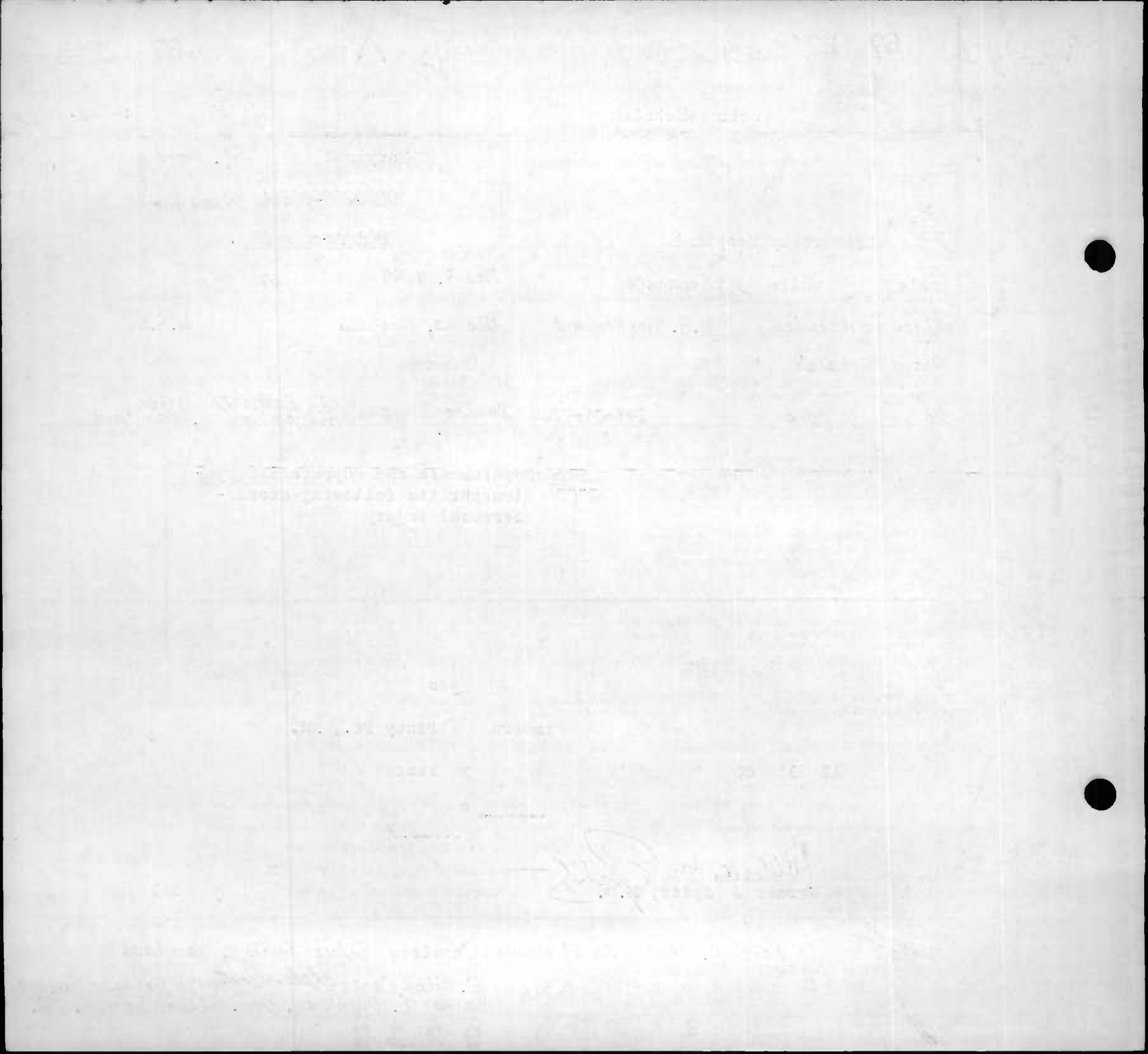
| | | | | | |
|---|--|--|------------------------------------|---|---|
| 48-75-84 IN -620 67 2217 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2217 | |
| BIRTH NO. 67 2217 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) NORRIS, Mary | | 2. DATE AND HOUR OF DEATH 3/2/67 5/30 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224 | | D. STREET ADDRESS (If rural, give location) 1370 N. CAREY STREET - 21217 | | 15-01 | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED | 8. DATE OF BIRTH 1/28/03 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME SAMUEL Taylor | | 14. MOTHER'S MAIDEN NAME RANDALL-Vertie | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 220-18-5211 | | 17. INFORMANT RECORDS: BCH, 4940 Eastern Avenue, Balto., Md. | |
| 18. 181.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of bladder DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 3 yrs. | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 4/27/66 8/22/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma bladder | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/23 19 67 to 3/2 19 67 , that (I) (we) last saw the deceased alive on 3/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David C. Swimmer | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/2/67 | |
| 23C. PHYSICIAN'S NAME (Type) DAVID SWIMMER | | 23D. ADDRESS BALTIMORE CITY HOSPITALS M.D. 4940 Eastern Avenue, Balto., Md. 21224 | | | |
| 24A. (URIAL) CREMATION, REMOVAL (Specify) | 24B. DATE 3/5/67 | 24C. NAME OF CEMETERY OR CREMATORY Carter's Ch. Cem. | | 24D. LOCATION (City, town, or county) (State) A.A. Co. | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR Prince Frederick, Md. | 25C. FUNERAL DIRECTOR Prince Frederick, Md. | | ADDRESS | |

3 NOV 1964
AMT 11:30 AM

BIRTH NO. **67 2218** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 2218**

M.E. CASE NO.

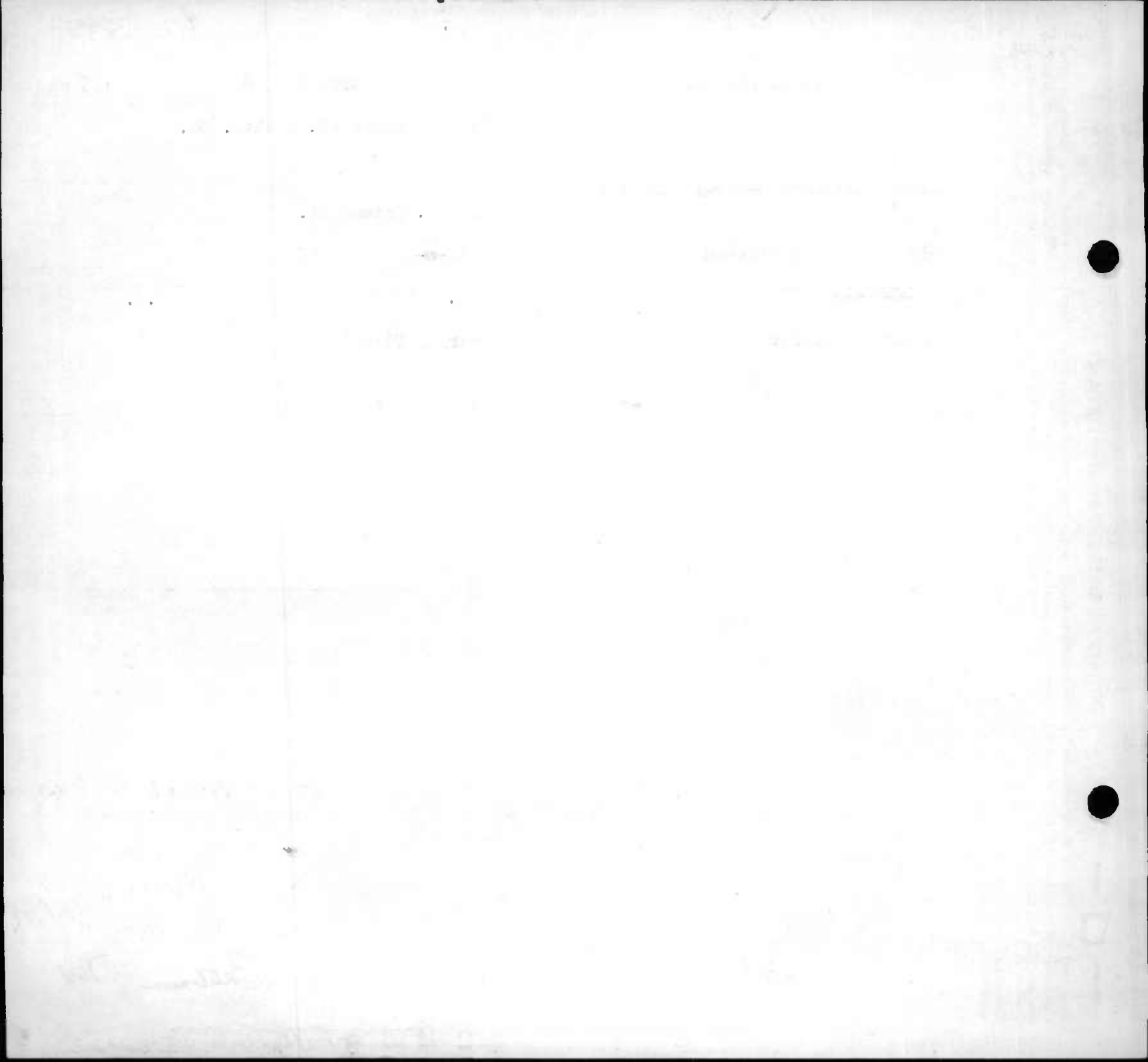
| | | | | | | | |
|---|-------------------------|--|--|--|---|--|--|
| 1. NAME OF DECEASED (Type or Print) John Michalek | | | | 2. DATE AND HOUR PRONOUNCED DEAD 3/1/67 3:40 p. M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 38 University Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY St. Mary's | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Piney Point 68-00 | | | |
| D. STREET ADDRESS (If rural, give location) 901 Annapolis Ave. | | | | | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated | 8. DATE OF BIRTH May 5, 1899 | 9. AGE (In years lost birthday) 67 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired bookbinder | | 10B. KIND OF BUSINESS OR INDUSTRY U.S. Government | | 11. BIRTHPLACE (State or foreign country) Vienna, Austria | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Franz Michalek | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 395-05-7724 | | 17. INFORMANT ADDRESS Louise Burgan 612 Lamberton Drive Silver Spring, Maryland | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 983X Bronchopneumonia and suppurative pyelonephritis following cranio-cerebral injury | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) tavern | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Piney Pt., Md. 68-00 | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 12 31 66 ? | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? beaten | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/2/67 ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE March 4, 1967 | | 23C. NAME OF CEMETERY or CREMATORY Gate of Heaven Cemetery | | 23D. LOCATION (City, town, or county) (State) Silver Spring, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 24B. NAME OF REGISTRAR Robert E. Folsom | | 24C. FUNERAL DIRECTOR C. Glen Carter 434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md. | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. 67 2219 | |
|--|-------------------------|---|------------------------------------|--|--|
| BIRTH NO. 67 2219 | | | | | |
| M.E. CASE NO. B | | | | | |
| 1. NAME OF DECEASED (Type or Print) James Wheeler | | 2. DATE AND HOUR OF DEATH March 4 1967 | | 8:15 pm M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 1238W Ostend St. B alto. Md. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Ind. | | | |
| | | D. STREET ADDRESS (If rural, give location) 1238 W. Ostend St. - 21230 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED Widowed | 8. DATE OF BIRTH 10-4-86 | 9. AGE (In years lost birthday) 80 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Self employed | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | |
| 13. FATHER'S NAME James B Wheeler | | 14. MOTHER'S MAIDEN NAME Mary E Simont | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/> | | 17. INFORMANT Frederick A. Brown 1149 W. Cross St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ASCVD; probable Gastrointestinal neoplasm - dehydration - Tuberculosis | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 23 1967 to March 4 1967 , that (I) (we) last saw the deceased alive on March 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert J. Hallen | | | | 23B. DATE SIGNED March 4 1967 | |
| 23C. PHYSICIAN'S NAME (Type) Robert J. Hallen | | 23D. ADDRESS South Baltimore Gen Hospital - Balt. Md. | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/67 | | 24C. NAME OF CEMETERY or CREMATORY Linden Park Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Ind. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR Robert E. Feltman | | 25C. FUNERAL DIRECTOR John J. Capron | |
| | | | | ADDRESS 2901 Hallens St - 21223 | |



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ESTHER M. HAAS

2. DATE AND HOUR PRONOUNCED DEAD

March 3, 1967 10:50 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3413 Harford Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3413 Harford Road

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Widowed

8. DATE OF BIRTH

July 1, 1898

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired Telephone Operator

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Marriott Chaney

14. MOTHER'S MAIDEN NAME

Rosenna E. Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
217-30-5120

17. INFORMANT

ADDRESS

21227

Mrs. Edith E. O'Loughlin, 125 Waelchli Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic heart disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springgate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 4, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-8-1967

23C. NAME of CEMETERY or CREMATORY

Cedar Hill Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 6 1967

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

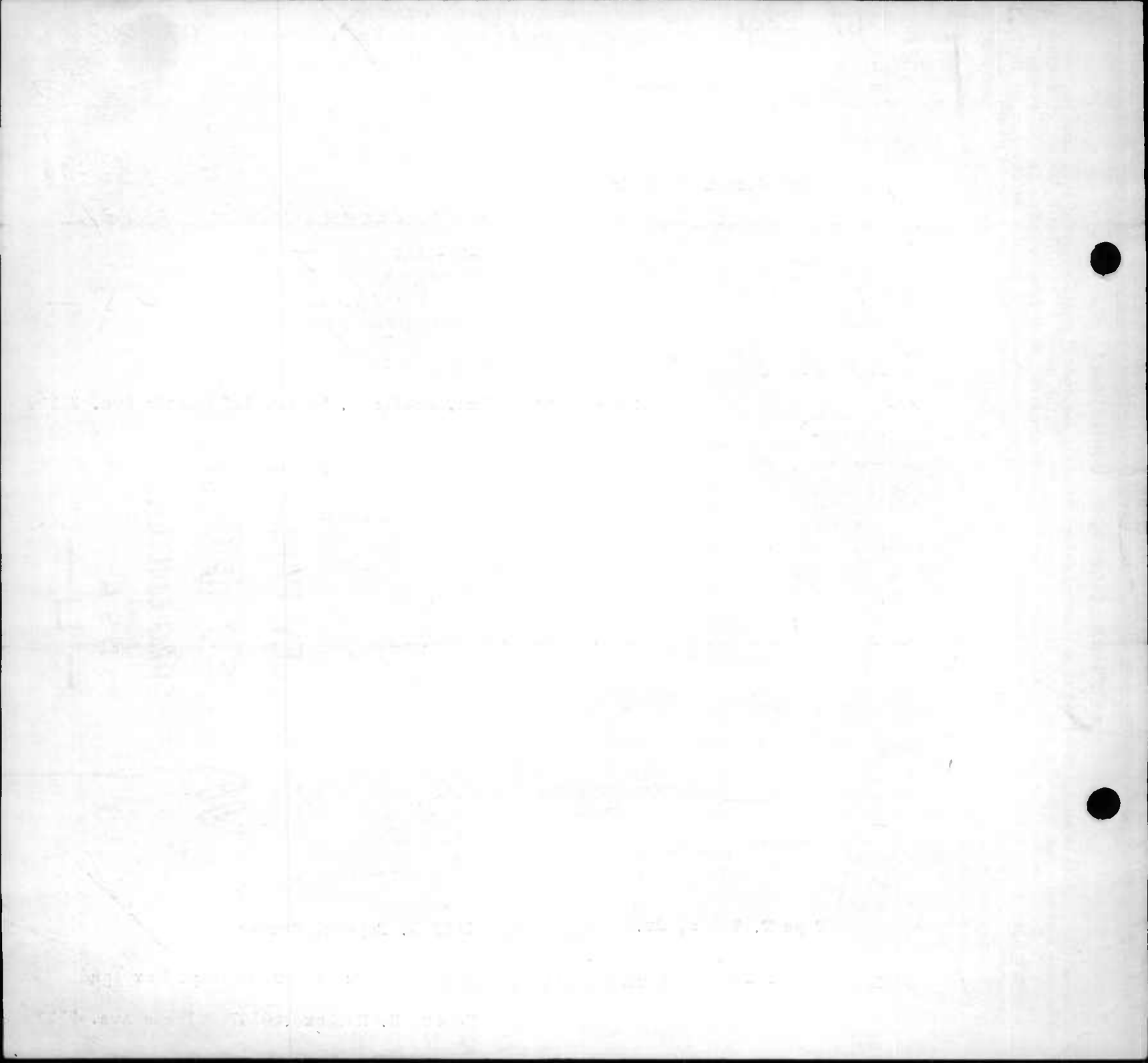
Howard H. Hubbard, 4107 Wilkens Ave. 21229

WALTER H. HARRIS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | | Registered No. <u>67 2221</u> |
|---|---------------------|---|--|---|--|--|--|--|--|-------------------------------|
| BIRTH NO. <u>67 2221</u> | | M.E. CASE NO. | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>MARY R. SCHWARTZ</u> | | | | | | 2. DATE AND HOUR OF DEATH <u>3/2/67</u> <u>5:15 P.M.</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>34 Bon Secours Hospital</u> | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>53-00</u> | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) <u>1020 Leeds Avenue</u> <u>21229</u> | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>W</u> | | 8. DATE OF BIRTH <u>7-24-1887</u> | 9. AGE (In years last birthday) <u>79</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 13. FATHER'S NAME <u>Henry B. Lingeman</u> | | | 14. MOTHER'S MAIDEN NAME <u>Isabelle Lowe</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>213-01-6220</u> | | 17. INFORMANT <u>Mrs. Stella B. Voyce, 1020 Leeds Ave. 21229</u> | | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>467.21</u> <u>Pulmonary embolism</u> | | | | CAUSE OF DEATH (A) DUE TO <u>to V6s occlusion</u> (B) DUE TO <u>occlusion of RT. leg.</u> (C) <u>—</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Uremia</u> | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/26</u> 19 <u>67</u> to <u>3/2</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/2</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <u>Jose T. Villa Jr.</u> | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>3/2/67</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Tope T. Villa, Jr.</u> | | | | | | 23D. ADDRESS M.D. <u>2025 W. Fayette Street</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3-6-67</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u> | | 25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u> | | ADDRESS | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--------------|---|---|--|---|--|--|--------------------------------|-------------------------------------|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2222 | | | | |
| BIRTH NO. 67 2222 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) MEEHAN, JOHN LEONARD | | | | | 2. DATE AND HOUR OF DEATH 3 MARCH 67 12 45 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL Hosp | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) XXXXXXXXXXXX Arbutus 53-00 D. STREET ADDRESS (If rural, give location) 1258 MAPLE AVE. | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 04-18-07 | 9. AGE (In years last birthday) 59 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | 11. BIRTHPLACE (State or foreign country) VA. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME JACK MEEHAN | | | | | 14. MOTHER'S MAIDEN NAME ALICE SMITH WICKLINE | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | | 16. SOCIAL SECURITY NO. 212-09-8926 | | 17. INFORMANT ADDRESS Mrs. Estella L. Meehan, 1258 Maple Ave. 21227 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 495X-260X Pneumonia | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. diabetes congestive heart failure, ASCVD | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from 2 FEB 1967 to 3 MARCH 1967, that (we) last saw the deceased alive on 3 MARCH 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Sidney E. Kirkley M.D. | | | | | | | | 23B. DATE SIGNED 3 March 67 | |
| 23C. PHYSICIAN'S NAME (Type) SIDNEY E. KIRKLEY, M.D. | | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-6-67 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | | 24D. LOCATION (City, town, or county) (State) 3801 Frederick Ave. Balto., Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR Howard H. Hubbard | | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |

MAR 6 1967

67 2222

W. 2
Carpenter, William
W. 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---|--|--|--|---|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2223 | | | | |
| BIRTH NO. 67 2223 | | M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) PHILLIP W. SIEMER | | | | | 2. DATE AND HOUR OF DEATH March 3, 1967 7:45 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 90 Hood Nursing Home 5213 Edmondson Avenue | | | | | A. STATE Maryland | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Morrell Park | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 25-52 1701 Wickes Avenue | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 2-6-1896 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Crane Operator | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Siemer | | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 212-07-5440 | | 17. INFORMANT Mrs. Frieda C. Polcak, 5621 Friendship Rd. | | | |
| | | | | ADDRESS 21227 | | | | | |
| 18. 332x1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH | | | | |
| | | | | | (A) Cerebral Thrombosis Right 19 days DUE TO (B) Cerebral Arteriosclerosis 4 years DUE TO (C) _____ | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| | | | | | Parkinson Disease 3 years | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/16 19 57 to 3/3 19 67 , that (I) was last saw the deceased alive on 3/2 19 67 and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE John P. Urlock Jr | | | | | | | | 23B. DATE SIGNED 3/3/67 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. John P. Urlock Jr | | | | | | | | 23D. ADDRESS 1227 Washington Blvd. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-7-67 | | 24C. NAME of CEMETERY or CREMATORY St. Pauls Lutheran Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR Robert E. Sabin | | 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | | |

7-17-79

10/10/79

Letter to the
Editor of the
New York Times

Dear Sir,

10/10/79

10/10/79

James P. Buckley Jr.

10/10/79

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

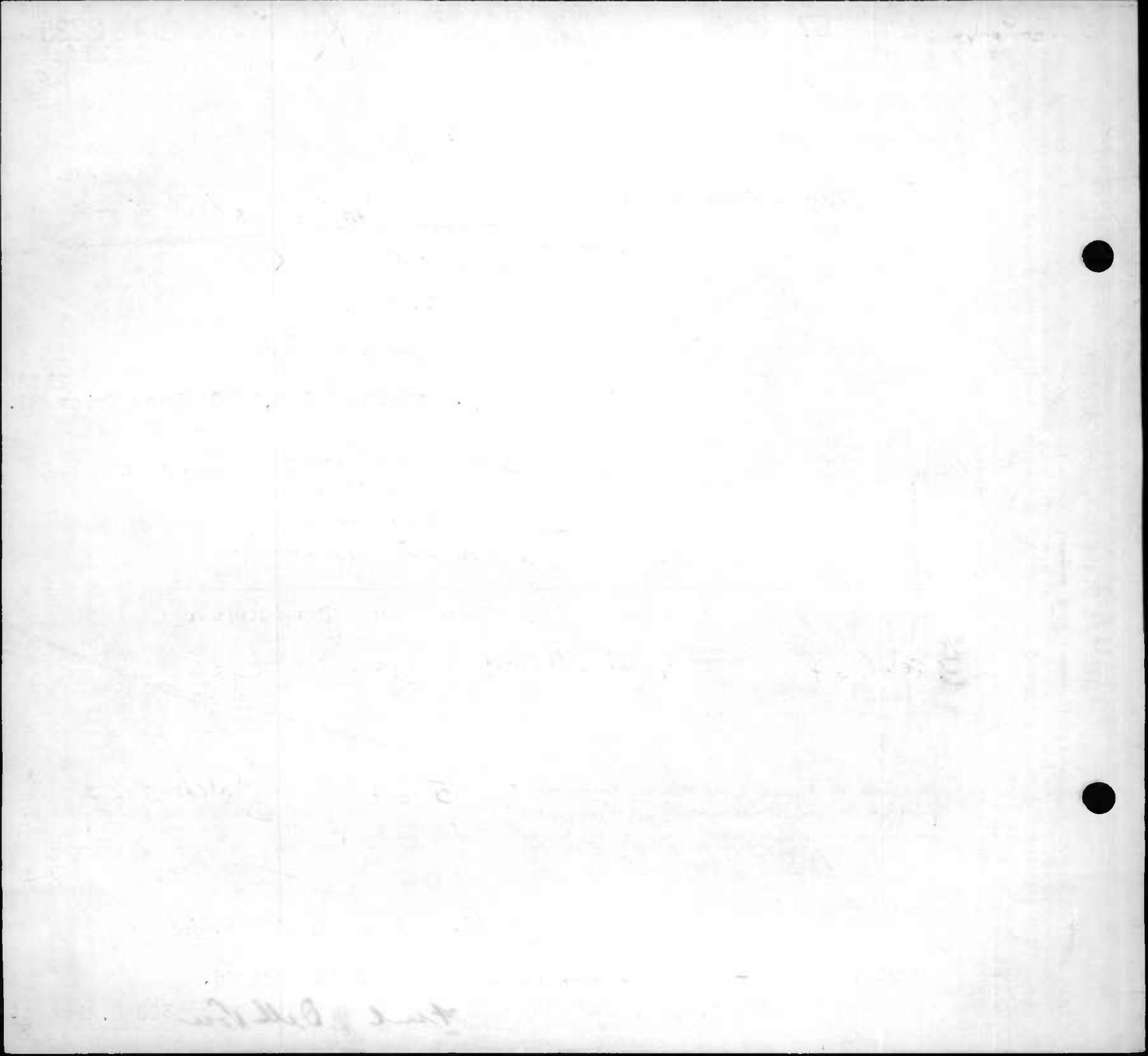
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|---|--|--|---|---|
| 67 2224 | | CERTIFICATE OF DEATH | | 67 2224 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | Sheppard, Dorothy W. | | 3-3-67 10:40A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| 40 St. Agnes Hospital | | Maryland | | Baltimore Co. | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Zone 21229 | |
| | | D. STREET ADDRESS (If rural, give location) | | 1045 Maiden Choice Lane 53-00 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| female | white | Married | 1-2-20 | 47 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Housewife | | | Maryland | | U.S.A. |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| M. Leon Woolford | | Agnes Lyons | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| | | 221 07 4181 | St. Agnes Hospital-Caton & Wilkens 21229 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 29 19 67 to March 3 19 67, that (I) (we) last saw the deceased alive on March 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. | Attending Phys. <input type="checkbox"/> | Med. Director <input type="checkbox"/> | Staff Phys. <input checked="" type="checkbox"/> |
| Pablo E. Dibos | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| PABLO DIBOS | | M.D. ST. AGNES HOSPITAL* CATON & WILKENS AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | 3-7-67 | Baltimore National Cemetery | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| MAR 6 1967 | Pablo E. Dibos | Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |

PAELO 01002

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2225 | |
|--|---------------------|--|------------------------------------|---|--|
| BIRTH NO. 67 2225 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Philomena Di Cesare</i> | | 2. DATE AND HOUR OF DEATH <i>3/3/67</i> <i>10⁰⁵ P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore Co.</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | D. STREET ADDRESS (If rural, give location) <i>1310 Blach Friars Road 21228</i> | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>W</i> | 8. DATE OF BIRTH <i>5/29/88</i> | 9. AGE (In years last birthday) <i>78</i> | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Italy</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>Nicholas Salza</i> | | 14. MOTHER'S MAIDEN NAME <i>Jennie Copano</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Mrs. Caroline Welsh, 1310 Blach Friar Rd. 21228</i> | |
| 18. <i>191.9 I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <i>one year</i> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO <i>Squamous cell carcinoma of anus & rectum & metastasis</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO <i>metastasis</i> | | | |
| (C) DUE TO <i>Generalized peritonitis</i> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <i>Aspiration pneumonia</i> | | | |
| 19A. DATE OF OPERATION <i>Feb 6/67</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Rectal bleeding</i> | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>no</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>Feb 5/67</i> 19 to <i>March 3/67</i> 19 | | that (I) (we) last saw the deceased alive on <i>March 3/67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE <i>A.M. Ghilardi</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>March 3/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS <i>Bon Secours Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3/7-67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i> | |
| 24D. LOCATION <i>Baltimore Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 6 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Spilhaus</i> | |
| 25C. FUNERAL DIRECTOR <i>Frank Della Vore</i> | | ADDRESS <i>322 S. High St</i> | | | |



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G-635

67 2226

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. Ft. Meade, Md. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2226

M.E. CASE NO.

| | | | | | |
|--|---------------------------|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) Gretchen Gardner | | | 2. DATE AND HOUR PRONOUNCED DEAD 3/5/67 4:30 a. m. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3809 Woodridge Ave. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3809 Woodridge Ave. | | |
| 5. SEX female | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Infant | 8. DATE OF BIRTH 1-11-1967 | | 9. AGE (In years last birthday) 1 21 1 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Fort Meade, Md. | |
| 13. FATHER'S NAME Leonard M. Gardner | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 14. MOTHER'S MAIDEN NAME Clara J. Johnson |
| 17. INFORMANT Mr. Leonard Johnson | | | ADDRESS 3809 Woodridge Rd | | |

| | | | | | |
|---|--|---|--|--|--|
| 18. CAUSE OF DEATH 525X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Interstitial Pneumonitis (SDII) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/5/67 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 2-8-67 | | 23C. NAME OF CEMETERY or CREMATORY Balto. National Cem. | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 24B. NAME OF REGISTRAR Robert E. Farber | | 24C. FUNERAL DIRECTOR Morton & Dyett | |
| | | | | ADDRESS F.H. 1701 Laurens St. | |

1951

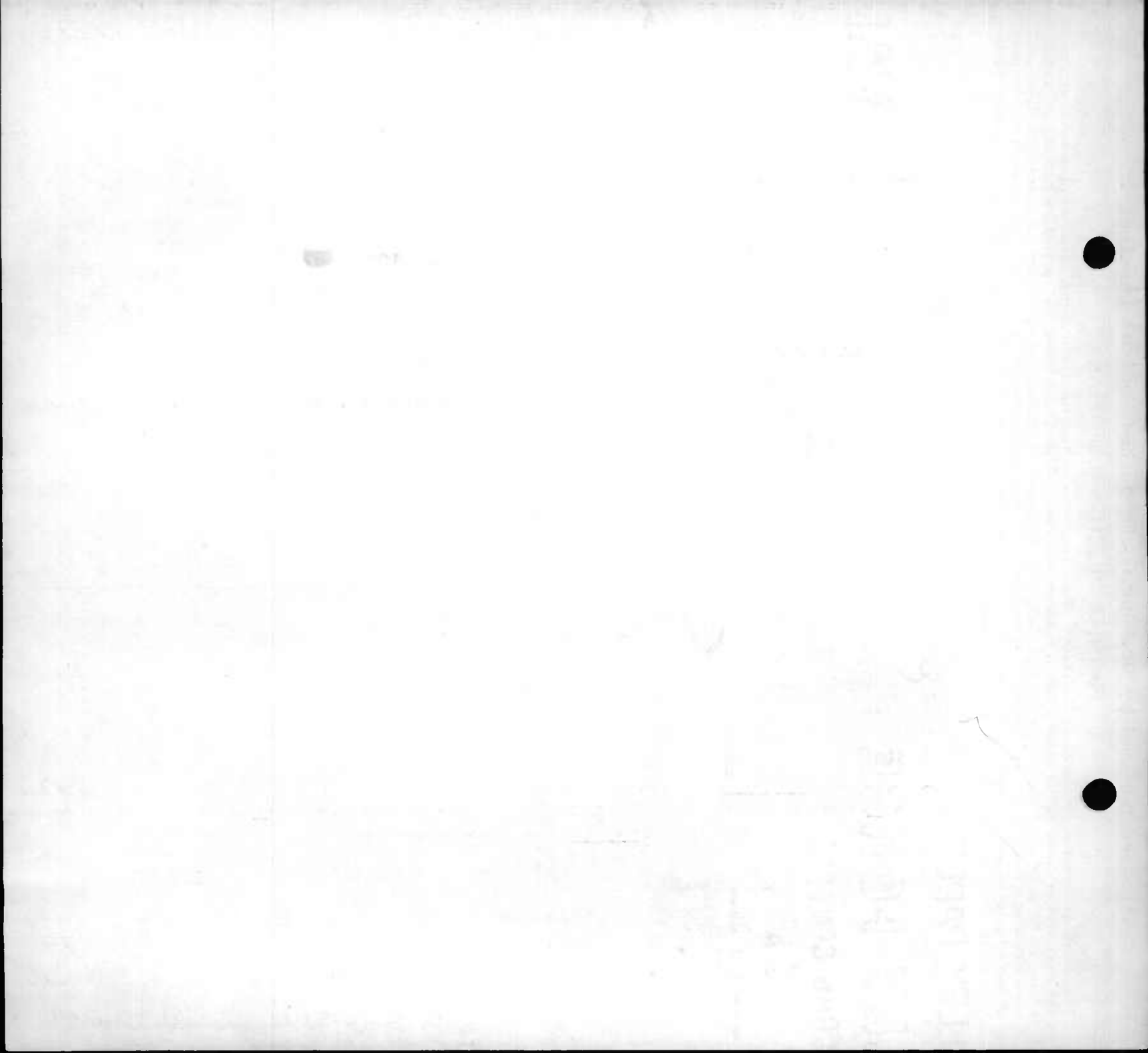
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2227 | |
|--|-------------------------|---|---------------------------------------|---|--|
| BIRTH NO. 67 2227 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>DOLLIE JOYNER</u> | | 2. DATE AND HOUR OF DEATH <u>3/3/67</u> <u>2:50 A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u> <u>33</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>1513 Kenhill Avenue</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>10/19/1900</u> | 9. AGE (In years last birthday) <u>66</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Littleton, N.C.</u> | |
| 13. FATHER'S NAME <u>Bill Morris</u> | | 14. MOTHER'S MAIDEN NAME <u>Jenny Barnes</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>225-28-3904</u> | | 17. INFORMANT <u>Mrs. Mary Wilson</u> | |
| | | | | ADDRESS <u>1513 N. Kenhill Ave</u> | |
| 18. <u>05341</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Antecedent causes</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>hypertension, nonketotic diabetic coma, pneumonia</u> | | CAUSE OF DEATH (A) <u>Cardiac arrest</u> (B) <u>Septic shock</u> (C) <u>Gram neg. sepsis</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>No</u> | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> 19 <u>67</u> to <u>3/3</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/3</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Kenneth C. Brigham</u> | | | | 23B. DATE SIGNED <u>3/3/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Kenneth C. Brigham</u> | | | | 23D. ADDRESS <u>Johns Hopkins Hospital</u> | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-7-67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Lebanon Exp. Ch. Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Renoke Rapids, N.C.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 6 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Jackson</u> | |
| 25C. FUNERAL DIRECTOR <u>Morton & Dyett F.H.</u> | | 25D. ADDRESS <u>1701 Laurens</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2228 | |
|--|--|--|--|--|-----------------------------|
| BIRTH NO. 67 2228 | | CERTIFICATE OF DEATH | | Registered No. 67 2228 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) STALEY BELLE | | 2. DATE AND HOUR OF DEATH 3-2-67 7 45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 46 LUTHERAN HOSPITAL OF MARYLAND | | A. STATE MARYLAND | | B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | D. STREET ADDRESS (If rural, give location) 619 Mt. Holly St | |
| 5. SEX ♀ | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH MARCH 14 83 | 9. AGE (In years last birthday) 83 | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Buffalo, N.C. | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME UNK. | | 14. MOTHER'S MAIDEN NAME Sarah Burrell | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Ida S. Faucett | | ADDRESS 1312 W. Mulberry |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) CVA | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) ASH CVD | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | RIGHT UPPER LOBE PNEUMONIA | | | |
| 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) YES | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DEC 20 19 66 to MARCH 2 19 67, that (I) (we) last saw the deceased alive on MARCH 2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Young Kil Kim M.D. | | | | 23B. DATE SIGNED 3-2-67 | |
| 23C. PHYSICIAN'S NAME (Type) YOUNG KIL KIM M.D. | | | | 23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 3-6-67 | 24C. NAME OF CEMETERY or CREMATORY Arbatus Mem. Park | 24D. LOCATION (City, town, or county) (State) Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 6 1967 | | 25B. NAME OF REGISTRAR R. B. E. Taylor | 25C. FUNERAL DIRECTOR Mortone & Dyck F.H. | ADDRESS 1701 LAURENS | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2229 | |
|---|--|---|--|---|--|
| BIRTH NO. 67 2229 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Marie R. Clampitt</i> | | 2. DATE AND HOUR OF DEATH <i>March 3 1967 3 Am.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>002312 Sulgrave Avenue</i> | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 27-15</i> | |
| D. STREET ADDRESS (If rural, give location) <i>2312 Sulgrave Avenue</i> | | 5. SEX <i>Female</i> 6. RACE <i>White</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Divorced</i> | | 8. DATE OF BIRTH <i>20 Sept 1894</i> 9. AGE (In years last birthday) <i>72</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House keeper</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Hugh W Costello</i> | | 14. MOTHER'S MAIDEN NAME <i>Anna Weber</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>217143324</i> | | 17. INFORMANT <i>Doris F Singer</i> ADDRESS <i>2312 Sulgrave Ave 21299</i> | |
| 18. <i>3-8-67</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) <i>? Pulmonary embolism</i> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i> | |
| (B) <i>Resolving cholecystitis</i> DUE TO | | (C) <i>Depressive reaction</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Feb 23 1967</i> to <i>Mar 3 1967</i> , that (I) we last saw the deceased alive on <i>Feb 25 1967</i> and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Louis H Schaffer</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>3/6/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Louis H Schaffer</i> | | M.D. 23D. ADDRESS <i>222 W Cold Spring Lane Brlto</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i> | | 24B. DATE <i>3-6-67</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem Baltimore Md</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 7 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | |
| 25C. FUNERAL DIRECTOR <i>Burgess Funeral Home</i> | | ADDRESS <i>3631 Falls Rd</i> | | | |

2012 Sulphur Avenue
 Frank Gehlke
 Diverced
 20201124 12
 2012 Sulphur Avenue
 Baltimore
 Maryland
 2012
 USA

Hugh W Costello
 Mrs

222 W Cold Spring Lane
 2012
 2012
 2012

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-100

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 2230

BIRTH NO.

67 2230

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Daisy L. Hebb

2. DATE AND HOUR OF DEATH

MARCH 2, 1967

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION

(If not in hospital or institution, give street
address or location)

3721 Roland Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

13-07

D. STREET ADDRESS (If rural, give location)

3721 Roland Avenue

5. SEX

female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Nov. 7, 1878

9. AGE (In years
last birthday)

88

If Under 1 Yr.
Months: Days:

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

At home

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA.

13. FATHER'S NAME

John Luther Leather

14. MOTHER'S MAIDEN NAME

MARY Lenhardt

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

John L. Menton 1719 Aberdeen Rd

ADDRESS

21204

18. 422.11

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Mar. 19 65 to Mar. 2 19 67.
that (I) (we) last saw the deceased alive on Mar. 1 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Edward L. Glassman

M.D.

Attending
Phys. ☒

Med.
Director ☐

Staff
Phys. ☐

23B. DATE SIGNED

3/3/67

23C. PHYSICIAN'S
NAME (Type)

EDWARD L. GLASSMAN

M.D.

23D. ADDRESS

4837 Falls Rd.

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

MAR 4, 1967 Meadowridge

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Howard County MD.

25A. DATE REC'D BY HEALTH DEPT.

MAR 7 1967

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Burgess Funeral Home

ADDRESS

3631 Falls Rd

Burgess Funeral Home

THE AVIATION POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 67 2231 | | CERTIFICATE OF DEATH | | Registered No. 67 2231 | | |
|--|------------------|---|----------------------------|---|----------------------------|---|-----------------------------|----------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) MARTIN SCHWARTZ | | | | 2. DATE AND HOUR OF DEATH MARCH 3, 1967 4:25 A.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL 36 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 20-06 D. STREET ADDRESS (If rural, give location) 2742 WILKINS AVE. | | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 2/5/03 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSISTANT FOREMAN | | 10B. KIND OF BUSINESS OR INDUSTRY Clothing | | 11. BIRTHPLACE (State or foreign country) RUSSIA | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME ISRAEL SCHWARTZ | | | | 14. MOTHER'S MAIDEN NAME BESSIE Gilburg - - | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 212 - 10 | | 17. INFORMANT CHART | | | ADDRESS | | | |
| 18. 592X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) DUE TO Chronic glomerulonephritis with (B) DUE TO uremia (C) | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from MAR. 1 19 67 to MAR. 3 19 67, that (I) (we) lost saw the deceased alive on MAR. 3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Ferdinand C. Rodriguez | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type) FERDINAND C. RODRIGUEZ | | | | 23D. ADDRESS M.D. FRANKLIN SQUARE HOSPITAL | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/6/67 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Cem | | 24D. LOCATION (City, town, or county) (State) Glen Burnie AA Co Md | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR McCully Funeral Home | | ADDRESS 237 Patapsco Av. | | | | |

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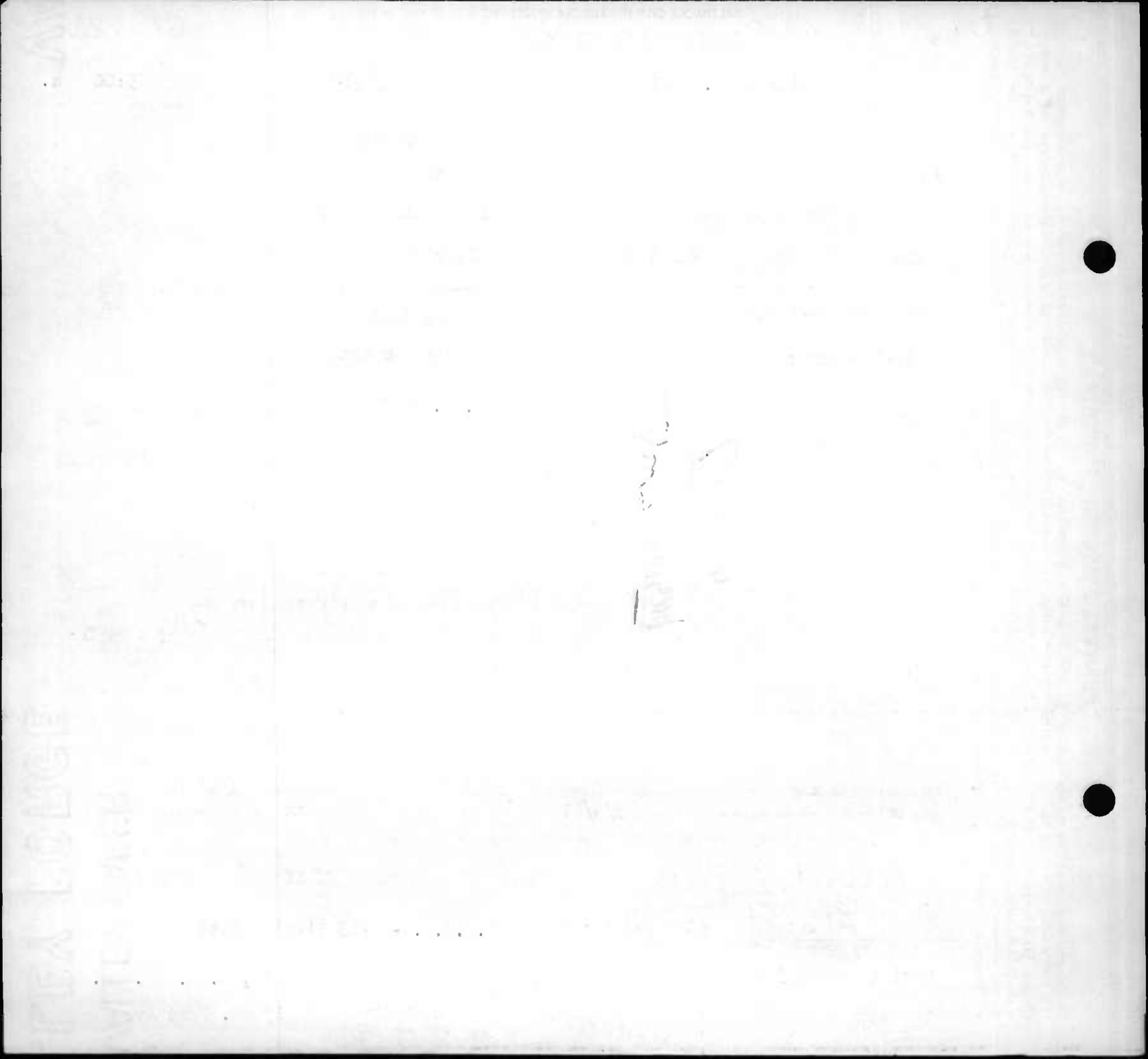
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|---|--|---|
| BIRTH NO. 67 2232 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 67 2232 | |
| 1. NAME OF DECEASED (Type or Print) William H. Davis | | | 2. DATE AND HOUR OF DEATH 3/5/67 5:00 a. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 SOUTH BALTIMORE GENERAL HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 24-04 D. STREET ADDRESS (If rural, give location) 1701 William Street | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 11/25/07 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Acme Warehouseman | | 10B. KIND OF BUSINESS OR INDUSTRY Warehouse | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME William Davis | | | 14. MOTHER'S MAIDEN NAME Addie Stevens | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 216 10 5646 | | 17. INFORMANT Wm. H. Davis |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of death, e.g., heart failure, asphyxia, etc. It means the disease or injury at complication which caused death.) 42011 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. Cor Pulmonale, Adrenal Atrophy? 89 yrs Bronchial asthma | | | CAUSE OF DEATH (A) Acute Myocardial Infarction (B) Arteriosclerotic cardiovascular disease? (C) 15 mins | | INTERVAL BETWEEN ONSET AND DEATH Same |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? Yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/2/67 19 to 3/5/67 19 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/5/67 19 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert T. Miller | | | | 23B. DATE SIGNED 3/6/67 | |
| 23C. PHYSICIAN'S NAME (Type) Albert T. Miller | | | | 23D. ADDRESS S.B.G.H. - 1213 Light Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3 8 67 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven | |
| 24D. LOCATION (City, town, or county) (State) Glen Burnie, A. A. Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Feltner | | 25C. FUNERAL DIRECTOR Mc Cully 130 E. Fort Ave Dr. Spitz | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2233 | |
|--|------------------|--|--|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67-2233 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Hepplestone, Jeffrey A.</i> | | 2. DATE AND HOUR OF DEATH <i>3/4/67 10:45 A.M.</i> | | | |
| 3. PLACE OF DEATH <i>IN BALTIMORE, MARYLAND</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind.</i> B. COUNTY <i>Calvert Co.</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Port Republic 54-00</i> | | | |
| D. STREET ADDRESS (If rural, give location) <i>Scientists Cciffs</i> | | | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>11/17/66</i> | 9. AGE (In years last birthday) <i>3</i> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Ind.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | | |
| 13. FATHER'S NAME <i>JAMES HUGGLESTONE</i> | | | 14. MOTHER'S MAIDEN NAME <i>LINDA MORRILL</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT <i>CHART</i> | |
| 18. <i>744.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Possible primary muscle disease</i> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 months</i> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Pneumonia</i> | | 4 days | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/28</i> 19 <i>67</i> to <i>3/4</i> 19 <i>67</i> . that (I) (we) last saw the deceased alive on <i>3/4</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Kurt Luddy</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>5/4/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Luddy</i> | | 23D. ADDRESS <i>University Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>Burial Mar. 4/77</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Christ Church Cemetery Port Republic Calvert Co. Md.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Port Republic Calvert Co. Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 7 1967</i> | | 25B. NAME OF REGISTRAR <i>R. E. E. Taylor, Jr.</i> | | 25C. FUNERAL DIRECTOR <i>G. A. Fagness & Son, Port Republic, Md.</i> | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------------|--|--|--|---|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>67 2234</u> | | | | |
| BIRTH NO. <u>67 2234</u> | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>MARSHALL CROWELL</u> | | | | | 2. DATE AND HOUR OF DEATH <u>MARCH 2, 1967</u> <u>6:00 A.M.</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>MARYLAND GENERAL HOSP.</u> <u>48 BALTO, MD.</u> | | | | | A. STATE <u>MD.</u> B. COUNTY | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTO.</u> | | | | | D. STREET ADDRESS (If rural, give location) <u>2909 White Ave. 21214</u> | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>12/3/91</u> | 9. AGE (In years last birthday) <u>75</u> | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane Operator</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. Contracting Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>MASS</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> | | |
| 13. FATHER'S NAME <u>MARSHALL CROWELL</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>ELNORA BURNS</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> | | | 16. SOCIAL SECURITY NO. <u>213-058793</u> | | 17. INFORMANT <u>Rose E. Crowell-2909 White Ave.</u> | | | | |
| 18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <u>Pulmonary emboli</u> DUE TO (B) <u>Generalized arteriosclerosis</u> DUE TO (C) <u>Arteriosclerotic Cardiovas. Dis.</u> | | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> | | | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>1. Chronic Renal Disease</u> <u>2. Chronic Brain Syndrome</u> <u>3. Anemia</u> <u>Unknown</u> <u>Approx. 2 years</u> <u>3 weeks</u> | | | | |
| 19A. DATE OF OPERATION <u>D</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that <u>he</u> (this hospital) attended the deceased from <u>1-18</u> 19 <u>67</u> to <u>3-2</u> 19 <u>67</u> , that <u>he</u> (we) last saw the deceased alive on <u>3-1</u> 19 <u>67</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Edward F. Cotter</u> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>Mar. 2, 1967</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Edward F. Cotter, M.D.</u> | | | | | 23D. ADDRESS <u>827 Linden Ave. (Maryland General Hosp)</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/7/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Gardens of Faith Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 7 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u> | | 25C. FUNERAL DIRECTOR <u>John C. Miller Inc</u> | | ADDRESS <u>-6415 Belair Rd.</u> | | | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 67 2235 | |
|--|---|--|--|--|---|---|---|
| BIRTH NO. 67 2235 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MINKE, EFFIE MARIE | | 2. DATE AND HOUR OF DEATH 3-2-67 6:30AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE 29, MD. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Allegheny Co | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) CUMBERLAND 51-02 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 410 ROBBINS TERRACE | | | |
| 5. SEX FEMALE | 6. RACE CAUCASION | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 08-23-09 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY Own home | | 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME UNKNOWN Albert Fresh (DEC'D) | | | | 14. MOTHER'S MAIDEN NAME AUTIE Strauser (DEC'D) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 214-05-4430 | | 17. INFORMANT ADDRESS #29 ST. AGNES RECORDS: WILKENS & CATON AVES. | | | |
| 18. 330 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | CAUSE OF DEATH (A) Sub ARACHNOID Hemorrhage DUE TO | | INTERVAL BETWEEN ONSET AND DEATH ~10 yrs | |
| | | | | (B) Inter Cranial Aneurysm DUE TO | | years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 24 19 67 to MARCH 2 19 67 , that (I) (we) last saw the deceased alive on MARCH 2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Frank M Detorie | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/2/67 | |
| 23C. PHYSICIAN'S NAME (Type) FRANK M DETORIE | | | | 23D. ADDRESS M.D. CATON AND WILKENS AVE. BALTO MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-6-1967 | | 24C. NAME of CEMETERY or CREMATORY Sunset Memorial Park | | 24D. LOCATION (City, town, or county) (State) Cumberland, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS George Funeral Home, Cumberland, Maryland | | | |

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 2236 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2236

M.E. CASE NO.

| | | | | | |
|---|------------------|--|-------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) | | MARIE DISTEFANO | | 2. DATE AND HOUR PRONOUNCED DEAD March 4, 1967 1:30 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital | | A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 53-00 D. STREET ADDRESS (If rural, give location) 2 Venus Court | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9/13/1929 | 9. AGE (In years last birthday) 37 | 10. Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10B. KIND OF BUSINESS OR INDUSTRY Dept. of Welfare | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Frank Sladek (Deceased) | | 14. MOTHER'S MAIDEN NAME Cekan (Deceased) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-26-6532 | | 17. INFORMANT Nicholas DiStefano 2 Venus Court. | |
| 18. 330X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH Ruptured intracranial saccular aneurysm (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2/ | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 4, 1967 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 3/7/1967 | | 23C. NAME OF CEMETERY or CREMATORY Holy Redeemer | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 24B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 24C. FUNERAL DIRECTOR Raymond C. Fink | |
| 24D. LOCATION Baltimore, Md. | | 24E. ADDRESS Glen Burnie, Md. | | 24F. ADDRESS | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2237 | |
|---|-------------------------|--|---|---|---|
| BIRTH NO. 67 2237 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MICHAEL C. LIPPERT | | 2. DATE AND HOUR OF DEATH March 1, 1967. 6:20 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 143 N. Ellwood Ave. Baltimore, 21224, Md. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore # 21224, 6-01 D. STREET ADDRESS (If rural, give location) 143 N. Ellwood Ave. | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH July 25, 1886 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Anne Laundry Co. | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME ? Lippert | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 213-10-5966 | | 17. INFORMANT Michael J. Lippert Balto., 24, Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic heart disease | | | 19. CAUSE OF DEATH (A) DUE TO Generalized arteriosclerosis (B) DUE TO (C) | | |
| 20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 22. I certify that (I) (this hospital) attended the deceased from August 2, 1957 to March 1, 1967 , that (I) (we) last saw the deceased alive on January 10, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 23A. SIGNATURE E. A. Flanagan Jr. | | 23B. DATE SIGNED 3/3/67 | |
| 23C. PHYSICIAN'S NAME (Type) Edward A. Flanagan, Jr. | | 23D. ADDRESS 3501 Fait Ave., Balto., 21224, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-4-67 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Charles J. Seifer | | 25D. ADDRESS 901 S. Conkling St. Balto., 21224, Md. | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2238 | |
|--|---|---|---|--|--|
| BIRTH NO. 67 2238 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Max Mary Kreiner | | 3/4/67 3:00 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital | | | A. STATE Maryland | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 702 | | |
| D. STREET ADDRESS (If rural, give location) 704 N. Belnord Avenue | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 11/31/87 | 9. AGE (In years last birthday) 79 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Czechoslovakia | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME John Taylor Tauber | | | 14. MOTHER'S MAIDEN NAME Mary Bieble | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-46-63851 | 17. INFORMANT Louis T. Kreiner | | ADDRESS 704 N. Belnord Ave. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 171X 260X Carcinoma of the Uterus with wide-spread metastases | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Cardiac arrest | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Paget Disease; Diabetes Mellitus | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/14 1967 to 3/4 1967 , that (I) last last saw the deceased alive on 300pm 3/4 1967 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Barry Verkauf | | | 23B. DATE SIGNED 3/4/67 | | |
| 23C. PHYSICIAN'S NAME (Type) Barry Verkauf | | | 23D. ADDRESS The Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-8-67 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR Philip E. Farkas | | 25C. FUNERAL DIRECTOR Philip E. Farkas | |
| | | | | ADDRESS 1211 Chesebrough Ave. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2239 | |
|--|------------------|---|--|--|--|
| BIRTH NO. 67 2239 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) DEAN LEINMANN | | | 2. DATE AND HOUR OF DEATH 3-4-67 3:40 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 7909 ST. GREGORY DRIVE | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 3-2-67 | 9. AGE (In years last birthday) 2 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME WILHELM LEINMANN | | | 14. MOTHER'S MAIDEN NAME INGE | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 762,01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO CARDIORESPIRATORY ARREST PREVIOUS CARDIO- RESPIRATORY ARREST (B) DUE TO ?? ASPIRATION (C) | | INTERVAL BETWEEN ONSET AND DEATH 30 MINUTES 12 HOURS |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 2, 19 67 to MARCH 4, 19 67, that (I) (we) last saw the deceased alive on MARCH 4, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J.A. ELLIOTT | | | | 23B. DATE SIGNED 3/5/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| CREMATION | | 3-5-67 | | JOHNS HOPKINS HOSPITAL BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAR 7 1967 | | J. J. F. F. | | HOSPITAL DISPOSAL | |

1 Y T

1997

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|------------------|---|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2240 | | | | | |
| BIRTH NO. 67 2240 | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Roscoe Horton</i> | | | | | 2. DATE AND HOUR OF DEATH <i>4 Mar 67 10²⁵ P M.</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | A. STATE B. COUNTY | | | | | |
| <i>University of Maryland Hospital</i> | | | | | <i>md Hartford Co</i> | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | | <i>Belcamp 62-00</i> | | | | | |
| D. STREET ADDRESS (If rural, give location) | | | | | | | | | | |
| | | | | | | | | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Separated Divorced</i> | | 8. DATE OF BIRTH <i>1/1/18</i> | 9. AGE (In years last birthday) <i>49</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lumberjack</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Wood cutting</i> | | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 13. FATHER'S NAME <i>Sam Horton</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i> | | | | | 16. SOCIAL SECURITY NO. <i>228-18-3621</i> | | 17. INFORMANT ADDRESS <i>Raynor K. Horton, Belcamp, Maryland</i> | | | |
| 18. <i>75471</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <i>Intraventricular Hemorrhage</i> DUE TO (B) <i>Arteriovenous malformation</i> DUE TO (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH <i>11 hrs</i> <i>> 4 months</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0 -</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>-</i> | | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>-</i> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i> | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i> | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>-</i> | | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? <i>-</i> | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from <i>2:35 pm 4 Mar 19 67</i> to <i>10:25 pm 4 Mar 19 67</i> , that (1) (we) last saw the deceased alive on <i>4 Mar 19 67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <i>Robert S. Holt, M.D.</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <i>4 Mar 67</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Robert S. Holt</i> | | | | | 23D. ADDRESS <i>University Hospital Baltimore Md.</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i> | | | 24B. DATE <i>Mar. 6, 1967</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Vaughan-Guyann F.H.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Hillsville Carroll Co., Va.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 7 1967</i> | | | 25B. NAME OF REGISTRAR <i>Robert S. Holt</i> | | | 25C. FUNERAL DIRECTOR ADDRESS <i>Howard K. McComas & Son, Abingdon, Md. 21009</i> | | | | |



1898

NO

[Handwritten signature]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2241

BIRTH NO. 67 2241

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Melvin Cornwell

2. DATE AND HOUR PRONOUNCED DEAD

3/4/67 8:10 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2827 Miles Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
MARRIED

8. DATE OF BIRTH

1/3/1914

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CHAUFFEUR

10B. KIND OF BUSINESS OR INDUSTRY

PUTTS + CALAHAN

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

705-10-8799

17. INFORMANT

ADDRESS

HELEN M. CORNWELL (SAME)

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic cardiovascular disease
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

3/5/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

3/8/67

23C. NAME OF CEMETERY OR CREMATORY

LORRAINE

23D. LOCATION

(City, town, or county)

(State)

BALTO. MD.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 7 1967

Robert E. Farber, M.D.

Paul L. Chernick, 3617 Chestnut Ave.

2006 FBI CONTACT

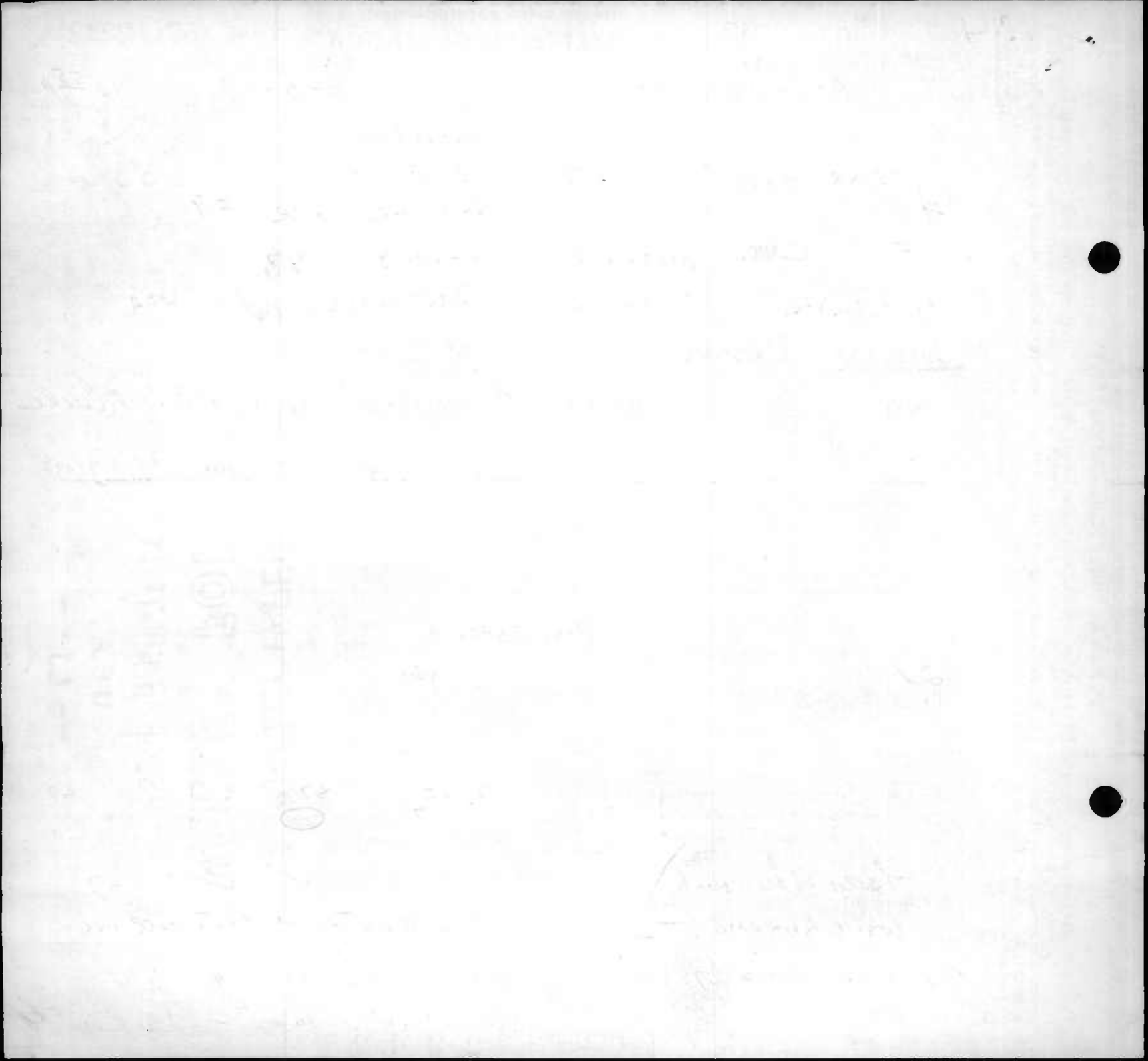
PROBES

William R. ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. <u>67 2242</u> | |
|---|-------------------------|--|---|--|---|---|------------------------------|--|---|--|--|
| BIRTH NO. <u>67 2242</u> | | | | | | | | | | BIRTH NO. <u>67 2242</u> | |
| M.E. CASE NO. <u>N</u> | | | | | | | | | | M.E. CASE NO. <u>N</u> | |
| 1. NAME OF DECEASED (Type or Print) <u>ANITA SINDLER</u> | | | | | 2. DATE AND HOUR OF DEATH <u>3-3-67</u> <u>10 55 P.M.</u> | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL of BALTO., INC</u> <u>42</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore Co</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2413 HAL CIRCLE #9</u> <u>53-00</u> | | | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>CAUC.</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>10-27-18</u> | 9. AGE (In years last birthday) <u>48</u> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, Md</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Salomon Desser</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Helen ?</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | | 17. INFORMANT <u>Russell Sinder - 2413 Hal Circle</u> | | | | | ADDRESS | |
| 18. <u>190.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Malignant Melanoma</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>PANCTOPENIA</u> | | | | | CAUSE OF DEATH (A) <u>Metastatic Malignant Melanoma</u> DUE TO (B) _____ DUE TO (C) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u> | |
| 19A. DATE OF OPERATION <u>2</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <u>no</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> 19 <u>67</u> to <u>3-3</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-3</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <u>Leslie Abramowitz</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>3-3-67</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Leslie Abramowitz</u> | | | | | 23D. ADDRESS M.D. <u>SINAI HOSPITAL OF BALTIMORE, INC.</u> | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>March 7</u> | | | 24C. NAME OF CEMETERY, CREMATORY <u>Bech Jacob</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Finksburg, Md</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 7 1967</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Fink</u> | | | 25C. FUNERAL DIRECTOR <u>Edgemon - 6010 West R</u> | | | ADDRESS | | |



BIRTH NO. 67 2243 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2243
 M.E. CASE NO. 66-09977

1. NAME OF DECEASED (Type or Print) STERLING D. JONES 2. DATE AND HOUR PRONOUNCED DEAD
March 4, 1967 9:35 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
 A. STATE Maryland B. COUNTY 15-02

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Sinai Hospital (DOA) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
1442 N. Mount Street

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) S 8. DATE OF BIRTH May 12, 1966 9. AGE (In years last birthday) 9 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant 10B. KIND OF BUSINESS OR INDUSTRY Baltimore, Md. 11. BIRTHPLACE (State or foreign country) Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME David Grey 14. MOTHER'S MAIDEN NAME Wanda Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT Wanda Jones 104 N. Schroeder St ADDRESS

18. 5-20-X I CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
 (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial pneumonitis (SDII)
 DUE TO

ANTECEDENT CAUSES
 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 21 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes. 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate CHIEF MEDICAL EXAMINER ☐ DATE SIGNED March 4, 1967
 EXAMINER'S NAME (Type) Charles S. Springate, M.D. M.D. ASSISTANT MEDICAL EXAMINER ☒
 ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 3/7/1967 23C. NAME OF CEMETERY or CREMATORY W. A. Brown Cem. 23D. LOCATION (City, town, or county) (State) Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 24B. NAME OF REGISTRAR Robert E. Fairbank 24C. FUNERAL DIRECTOR Williams Funeral Home ADDRESS 319 N. Schroeder St

May 1916
Barto. M.
James Jones

WILLIAM BARTO

David L.

WILLIAM BARTO
James Jones

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 2244**

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DAVID LEE HICKSTALL

2. DATE AND HOUR PRONOUNCED DEAD

March 4, 1967 3:00 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2502 W. Baltimore Street

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2242 W. Baltimore Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

July 13, 1923

9. AGE (In years
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cement Finisher

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

David Cooper

14. MOTHER'S MAIDEN NAME

Catherine Hickstall

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

229-16-8353

17. INFORMANT

Catherine Hickstall 2242 W. Baltimore St.

18. **E9811**

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, pneumonia, etc. It means the disease,
injury or complication which caused death.)(A) _____
DUE TO

Shotgun wound of abdomen

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

house

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2502 W. Baltimore St. 1st Floor

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3-4-67 approx. 2:00 A.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot during altercation

20-02

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 4, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/7/1967

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

Baltimore, Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 7 1967

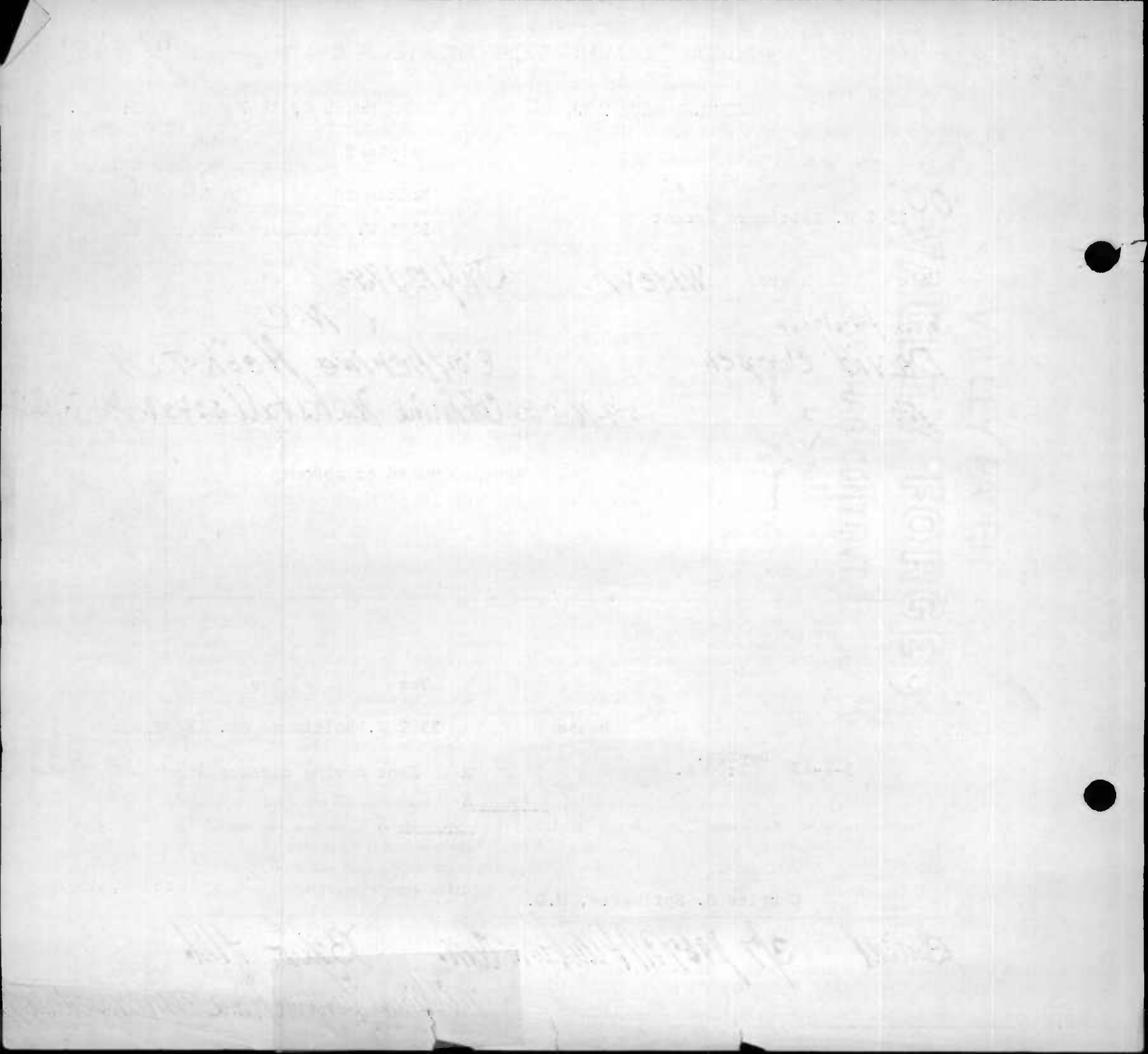
24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Williams Funeral Home 314 N. Broadway

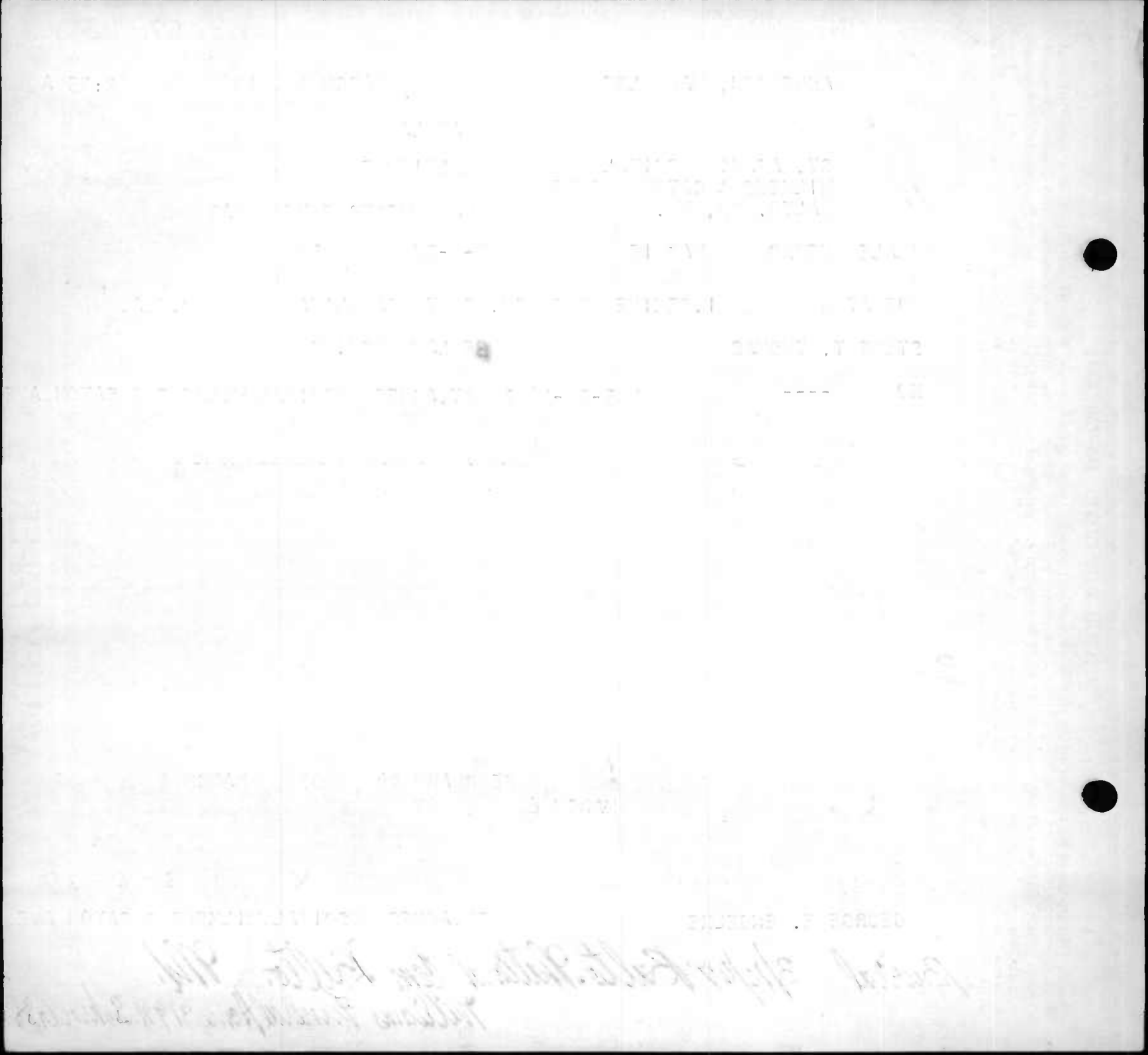
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. 67 2245 | |
|--|------------------|--|----------------------------|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 2245 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) ANDERSON, MARY LEE | | 2. DATE AND HOUR OF DEATH MARCH 6, 1967 12:25 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO. 29, MD. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 28-03 D. STREET ADDRESS (If rural, give location) 4028 WESTCHESTER ROAD | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 2-2-35 | 9. AGE (In years last birthday) 32 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR | | 10B. KIND OF BUSINESS OR INDUSTRY I. SEKINE BRUSH CO. | | 11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA | |
| 13. FATHER'S NAME STEVE T. THOMAS | | 14. MOTHER'S MAIDEN NAME BEULAH HUGGINS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213-32-3483 | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 214 X I II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Due to Post Operative Peritonitis and Atelectasis (B) Due to (C) | | INTERVAL BETWEEN ONSET AND DEATH 4.5 days | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 3-28-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Uterine Fibroids | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 24 19 67 to MARCH 6 19 67, that (I) (we) last saw the deceased alive on MARCH 6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE George E. Engelke M.D. 23B. DATE SIGNED 3-6-67 | | | |
| 23C. PHYSICIAN'S NAME (Type) GEORGE E. ENGELKE | | 23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/30/67 | | 24C. NAME OF CEMETERY OR CREMATORY Balto. National Cem. Balto. Md. | |
| 24D. LOCATION (City, town or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Williams Funeral Home | | 25D. ADDRESS 319 N. Schroeder St. | | | |



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0-416

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 2246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2246

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GEORGE M. OLIVER 2. DATE AND HOUR PRONOUNCED DEAD March 3, 1967 9:05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1405 E. Lanvale Street C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-09

D. STREET ADDRESS (If rural, give location) 1405 E. Lanvale Street

5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed 8. DATE OF BIRTH Dec. 13, 1906 60 9. AGE (In years last birthday) 10. If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

18. CAUSE OF DEATH 19. INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Organizing tuberculous pneumonia (A) DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (Partial)

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK [] 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry [] Inspection [] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [] Suicide [] Homicide [] Undetermined manner []

ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER [] DATE SIGNED ASSISTANT MEDICAL EXAMINER [X] ASSOCIATE MEDICAL EXAMINER []

NAME (Type) Charles S. Springate, M.D. March 3, 1967

23A. BURIAL CREMATION, REMOVAL (Specify) 23B. DATE 23C. NAME OF CEMETERY or CREMATORY 23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT. 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR ADDRESS

WILLIAM DOUGLAS

00

Forrest Mount
Coral Gables

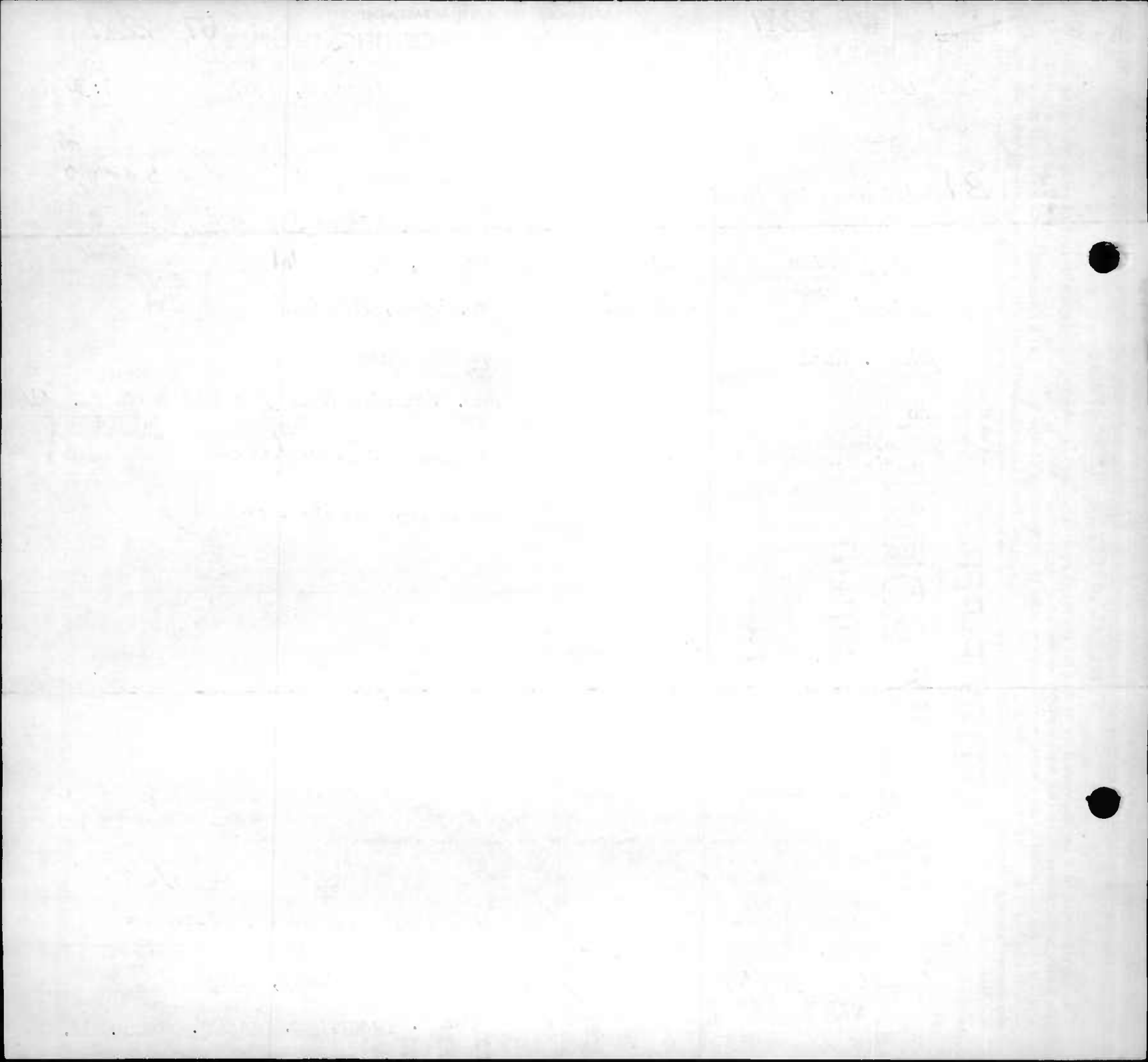
Walter D. Brown

1111
The Mills

of the University of California
at Berkeley

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2247 | |
|--|--|---|---|---|---|
| <div style="display: flex; justify-content: space-between;"> BIRTH NO. 67 2247 CERTIFICATE OF DEATH </div> | | | | | |
| <div style="display: flex; justify-content: space-between;"> M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <i>LeRoy A. Karl</i> 2. DATE AND HOUR OF DEATH <i>March 6, 1967 1:30 A.M.</i> </div> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <div style="display: flex;"> <div style="flex: 1;"> FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospital</i> </div> <div style="flex: 1; font-size: small;"> (If not in hospital or institution, give street address or location) </div> </div> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <div style="display: flex;"> <div style="flex: 1;"> A. STATE <i>Maryland</i> </div> <div style="flex: 1;"> B. COUNTY <i>Balt. Co.</i> </div> </div> | | |
| 5. SEX <i>Male</i> | | | 6. RACE <i>White</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> |
| 8. DATE OF BIRTH <i>March 1, 1906</i> | | 9. AGE (In years last birthday) <i>61</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>John G. Karl</i> | |
| 14. MOTHER'S MAIDEN NAME <i>Myrtle Durr</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | |
| 17. INFORMANT <i>Mrs. Veronica Karl</i> | | ADDRESS <i>3705 Old North Pt. Rd.</i> | | | |
| 18. CAUSE OF DEATH <div style="display: flex;"> <div style="flex: 1;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="flex: 1;"> (A) DUE TO <i>myocardial infarction</i> (B) DUE TO <i>Coronary occlusion</i> (C) </div> <div style="flex: 1;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5/29/67</i> to <i>3/5/67</i>, that (I) (we) last saw the deceased alive on <i>2/29/67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>J. Platt</i> | | | | 23B. DATE SIGNED <i>3/6/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>J. PLATT</i> | | | | 23D. ADDRESS <i>406 EASTERN BLVD EMD.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3/9/67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 7 1967</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i> | | | |
| ADDRESS <i>3000 E. Balto. St.</i> | | | | | |



B-355 67 2248

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2248

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|--|--|--|
| BIRTH NO. 67 2248 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) REDMOND, THOMAS E. REDMOND, THOMAS E. | | 2. DATE AND HOUR OF DEATH 3/5/67 8 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY Maryland | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 19-01 | |
| D. STREET ADDRESS (If rural, give location) 437 N. Gilmore Street #21223 | | 5. SEX Male M 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | |
| 8. DATE OF BIRTH 3-29-1897 9. AGE (In years last birthday) 69 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Sam Redmond (Deceased) | | 14. MOTHER'S MAIDEN NAME Rose Johnson (Deceased) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT BCH 4940 Eastern Avenue | | ADDRESS Baltimore, Maryland #21224 | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. DATE OF OPERATION 2/27/67 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA of PROSTATE | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work Not While At Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (his hospital) attended the deceased from 2/18 19 67 to 3/5 19 67, that (I) (we) last saw the deceased alive on 3/5 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE Stuart Beal Silver M.D. Attending Phys. Med. Director Stoll Phys. 23B. DATE SIGNED 3/5/67 | |
| 23C. PHYSICIAN'S NAME (Type) STUART BEAL SILVER | | 23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. #21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 3/8/67 | | 24C. NAME OF CEMETERY OR CREMATORY BORTSMOUTH VA. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR P. H. 63 8N 61 C. M. ST. | |

WATER LOGS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 2249 | |
|--|---|---|--|---|---|--|--|
| BIRTH NO. 67 2249 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Matthews A. Jenkins | | 2. DATE AND HOUR OF DEATH 3-6-1967 10 25 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland 46 730 Ashburton Street | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-04 D. STREET ADDRESS (If rural, give location) 1914 Pulaski Street 21217 | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 3-12-21 | 9. AGE (In years last birthday) 45 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fork Lift Operator Hecht Co. | | 11. BIRTHPLACE (State or foreign country) Virginia |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME William Jenkins | | | |
| 14. MOTHER'S MAIDEN NAME Eleanor Burton | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes World War II | | | |
| 16. SOCIAL SECURITY NO. 217-18-0169 | | | | 17. INFORMANT ADDRESS Gladys Jenkins - 1914 Pulaski St. | | | |
| 18. CAUSE OF DEATH 330X I | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subarachnoid Hemorrhage | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO Probably ruptured Aneurysm | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-6-67 19 to 3-6-67 19, that (I) (we) last saw the deceased alive on 3-6-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Ewald H. Weiss | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) Ewald H. Weiss | | | | 23D. ADDRESS M.D. Lutheran Hosp of Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/10/67 | | 24C. NAME OF CEMETERY OR CREMATORY BALTO NATIONAL | | 24D. LOCATION (City, town, or county) (State) BALTO MD | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR R. E. Fisher | | 25C. FUNERAL DIRECTOR Marshall P. Hays | | ADDRESS 635 N. GILMAN | |

40

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 67 2250 | | CERTIFICATE OF DEATH | | Registered No. 67 2250 | |
|---|---------------------|---|--|--|--|--|--|-----------------------------|--|
| 1. NAME OF DECEASED (Type or Print) LEWIS MATTIE | | | | 2. DATE AND HOUR OF DEATH 3.5.1967 | | 7-35 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3110 PRESBURY ST | | | | | |
| 5. SEX F. | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 10.1.34 | 9. AGE (In years last birthday) 32 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher-Ret. | | 10B. KIND OF BUSINESS OR INDUSTRY College Virginia State | | 11. BIRTHPLACE (State or foreign country) VIRGINIA, Northumberland Co. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A | | | |
| 13. FATHER'S NAME John H. Ellison | | | | 14. MOTHER'S MAIDEN NAME Eliza Dawson | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS SHIRLEY STROTHER 3110 PRESBURY ST | | | | | |
| 18. 293X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) URAEMIA | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH One week | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SEVERE ANEMIA | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3.5.1967 12:30 PM to 3.5.1967 that (I) (we) last saw the deceased alive on 3.5.1967 7:35 PM and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE V. Biswanath Pillai | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/6/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) V. BISWANATH PILLAI | | | | 23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/11/67 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR Herbert E. Nutter | | 25C. FUNERAL DIRECTOR Herbert E. Nutter-3035 W. North Ave. | | ADDRESS | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2251 | |
|---|---|--|---|---|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 2251 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) James W. Gaskins | | 2. DATE AND HOUR OF DEATH March 5-1967 8:30 AM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital 42 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 13-04 | | | |
| | | D. STREET ADDRESS (If rural, give location) 2301 OREM AVE | | | |
| 5. SEX MALE | 6. RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH Feb 28, 1902 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CRANE OPERATOR | | 10B. KIND OF BUSINESS OR INDUSTRY DUPONT Chemical Co | | 11. BIRTHPLACE (State or foreign country) Northumberland Co, VA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | | | | |
| 13. FATHER'S NAME JAMES HENRY Gaskins | | 14. MOTHER'S MAIDEN NAME LOVIE Robinson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 219-07-2356 | | 17. INFORMANT MRS. ANNA R. Gaskins | |
| | | | | ADDRESS 2301 OREM AVE | |
| 18. 420.1 I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Arterio sclerosis | | unknown | |
| | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-11 1966 to 3-5 1967, that (I) (we) last saw the deceased alive on January 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David I. Miller | | | | 23B. DATE SIGNED 3-5-67 | |
| 23C. PHYSICIAN'S NAME (Type) David I. Miller | | | | 23D. ADDRESS Linson Rd - Owings Mills Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/67 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | |
| 24D. LOCATION Arbutus BALD Co, Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR Herbert E. Muttter | | 25C. FUNERAL DIRECTOR HERBERT E. MUTTER | |
| | | | | ADDRESS 3035 W. NORTH AVE | |

Since Hospital

Myocardial Infarction
Aortic regurgitation

January

David I. Miller
David P. Miller

3-11

✓

3-2

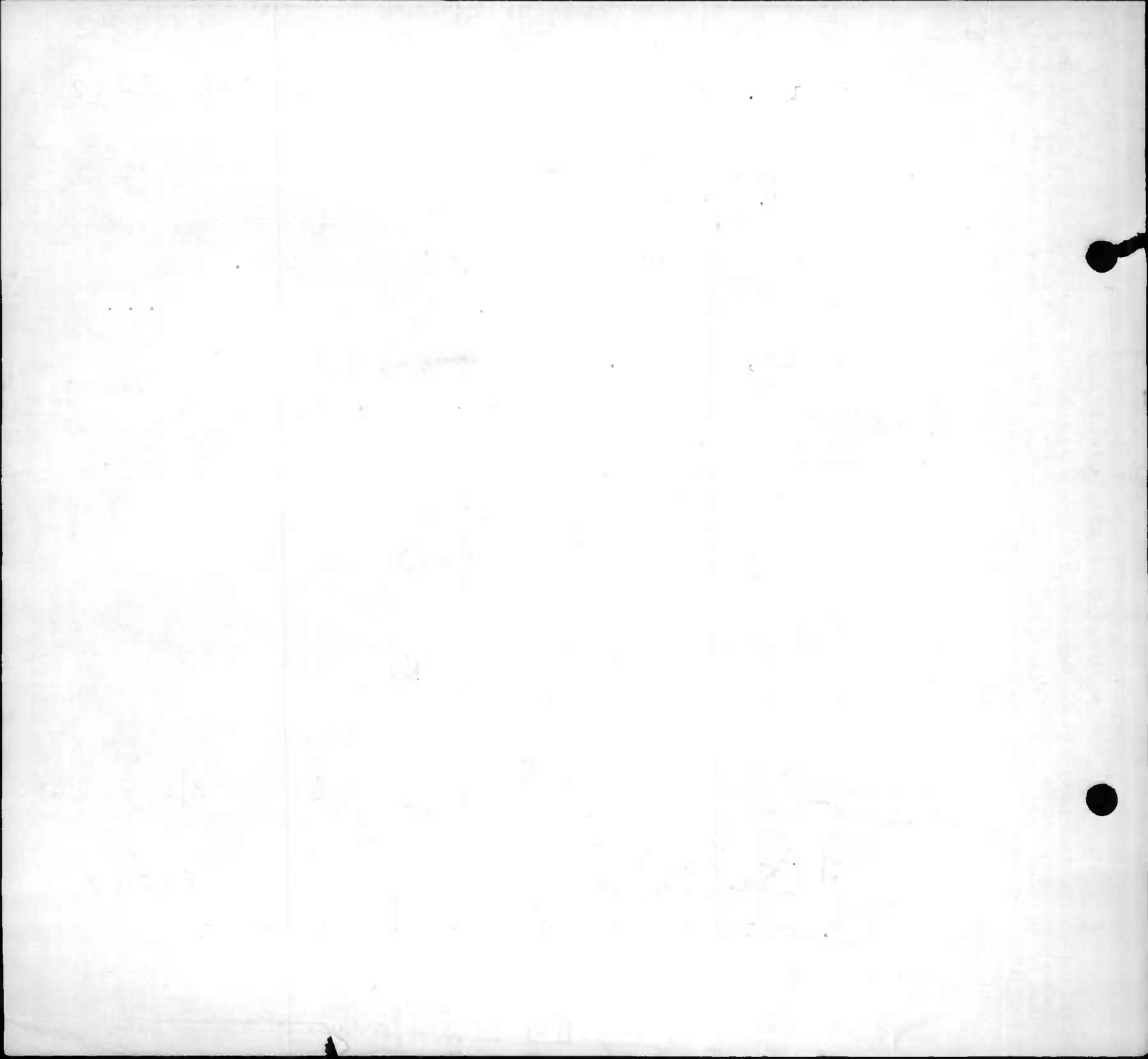
3-2

Green Rd. - Long Mill

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2252</u> | |
|--|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. <u>67 2252</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH <u>6:30 PM 13-2-67</u> M. | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Malcolm P. Chamberlain</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u> <u>601 N. Broadway</u> <u>Baltimore, Maryland 21205</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>3339 Piedmont Avenue</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>1/19/86</u> | 9. AGE (In years last birthday) <u>80 yrs.</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur - Foreman</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Balto City Water Dept.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Middlesex, Co, Va</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME <u>Chamberlain, Malcolm Sr.</u> | | 14. MOTHER'S MAIDEN NAME <u>Janiser Cauthorne</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>220-44-4576</u> | | 17. INFORMANT <u>Mrs. Annie M. Chamberlain</u> ADDRESS <u>3339 Piedmont Ave</u> | |
| 18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <u>Pneumonia</u> (B) <u>Stroke</u> (C) <u>Acid</u> INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> 19 <u>67</u> to <u>3/2</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/2</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>F. Ismail Beigi</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>3-2-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>F. Ismail Beigi</u> | | 23D. ADDRESS M.D. <u>The Johns Hopkins Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/6/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u> | |
| 24D. LOCATION <u>Arbutus Balto Co, Md</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>Herbert E. Nutter</u> | | 25C. FUNERAL DIRECTOR <u>3035 W. North Ave</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2253 | |
|---|---------------------------|---|------------------------------------|--|---|
| BIRTH NO. 67 2253 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) LAURENCE Williams | | | | March 5, 1967 7:45 PM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Maryland | | | | A. STATE Maryland | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) 2111 Garrison Blvd. 21216 | |
| 5. SEX Male | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4-29-99 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cauffeur | | 10B. KIND OF BUSINESS OR INDUSTRY Private Family | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Benjamin Williams | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. Medicare | |
| 17. INFORMANT Mrs Mamie William 2111 Garrison Blvd. | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asthma, etc. It means the disease or complication which caused death.) Cerebrovascular accident (Non traumatic) emb | | | | INTERVAL BETWEEN ONSET AND DEATH 15 h | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, give rise to the above cause (A) stating UNDERLYING CONDITION last. II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION WAS PERFORMED ✓ | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home (Baltimore) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) at home, 2111 Garrison Blvd | |
| 21D. TIME OF INJURY (APPROX.) AM 3:15/67 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> No While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fell out of bed | |
| 22. I certify that (I) (this hospital) attended the deceased from 7 AM 3/5/1967 to 7:45 PM 3/5/1967 , that (I) (we) last saw the deceased alive on 3/5/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Nguyen Thi Oanh | | | | 23B. DATE SIGNED 3/5/67 | |
| 23C. PHYSICIAN'S NAME (Type) NGUYEN THI OANH | | | | 23D. ADDRESS Lutheran Hospital of Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/9/67 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR Robert E. Fink | | 25C. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave. | |

Testimony of [Name]

Witness

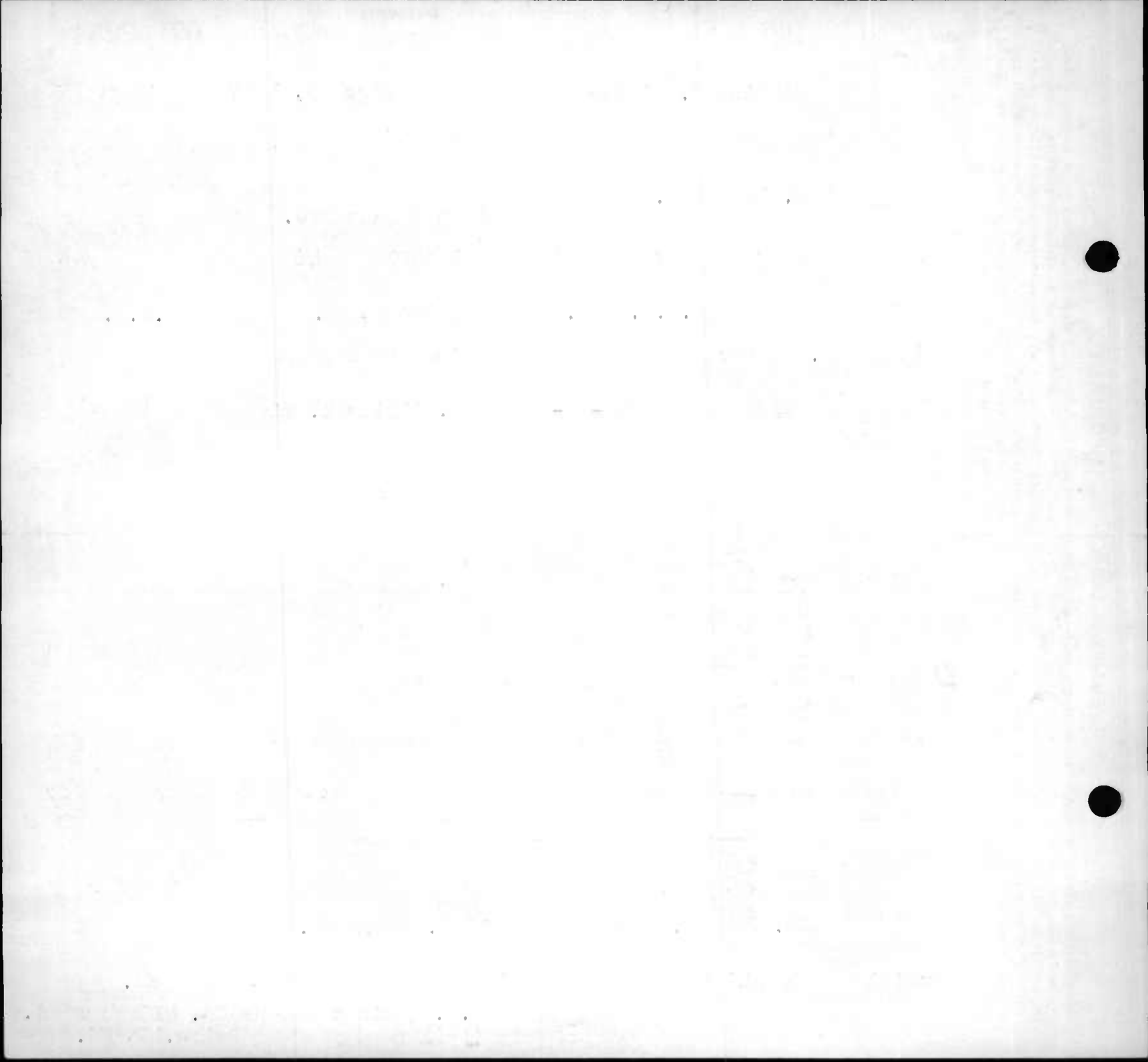
[Signature]

[Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2254</u> | |
|--|---------------------|---|---|--|---|
| BIRTH NO. <u>67 2254</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <u>William H. Victor</u> | | | March 5, 1967 10:40 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>00 4 W. Lake Ave.</u> | | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | |
| | | | D. STREET ADDRESS (If rural, give location) <u>4 West Lake Ave.</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never Married</u> | 8. DATE OF BIRTH <u>2/1/1921</u> | 9. AGE (In years last birthday) <u>46</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auditor</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>U.S.F. & G.</u> | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>William H. Victor</u> | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Brannan</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWII</u> | | 16. SOCIAL SECURITY NO. <u>216-18-6356</u> | 17. INFORMANT <u>Mrs. William H. Victor</u> | | ADDRESS <u>(Same)</u> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>157X I</u> <u>Carcinoma of pancreas (metastatic)</u> | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 years</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>Dec. 1963</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Jaundice (harmless)</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 22</u> 19 <u>66</u> to <u>March 5</u> 19 <u>67</u> , that (I) (was) last saw the deceased alive on <u>March 5</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>John Tilden Howard</u> | | | | 23B. DATE SIGNED <u>March 7, '67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. John T. Howard</u> | | 23D. ADDRESS <u>12 E. Eager St.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/9/1967</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 7 1967</u> | | 25B. NAME OF REGISTRAR <u>R. E. Farkema</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|--|---|--|--|--|
| 67 2255 | | 67 2255 | | 67 2255 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 14 10 p.m. | |
| 1. NAME OF DECEASED (Type or Print) <i>Greenlee Oden</i> | | 2. DATE AND HOUR OF DEATH <i>3-6-67</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <i>Church Home & Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i> | | | |
| 5. SEX <i>M</i> | | 6. RACE <i>W</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | |
| 8. DATE OF BIRTH <i>3-31-15</i> | | 9. AGE (In years last birthday) <i>54</i> | | 10. CITIZEN OF WHAT COUNTRY? <i>American</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>American</i> | | | |
| 13. FATHER'S NAME <i>Robert Oden Greenlee</i> | | 14. MOTHER'S MAIDEN NAME <i>Sarah Proctor</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW II</i> | | 16. SOCIAL SECURITY NO. <i>213-01-5297</i> | | 17. INFORMANT ADDRESS <i>Mrs. Anna L. Greenlee 320 S. Maderia Street</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO <i>metastatic Carcinoma</i> (B) DUE TO <i>Primary undetermined</i> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. DATE OF OPERATION <i>October 1966</i> | | 20. AUTOPSY? (Yes or No) <i>Yes</i> | | 21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2-11-1967</i> to <i>3-6-1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | 23. SIGNATURE <i>Alfred T. Cox</i> | | 24. DATE SIGNED <i>Mar. 6, 1967</i> | |
| 25. DATE RECEIVED BY HEALTH DEPT. <i>MAR 7 1967</i> | | 26. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 27. FUNERAL DIRECTOR ADDRESS <i>Lilly & Zeiler Inc. 1901-07 Eastern Ave.</i> | |

General Thomas A. ...

Robert ...
3-31-12

...

...

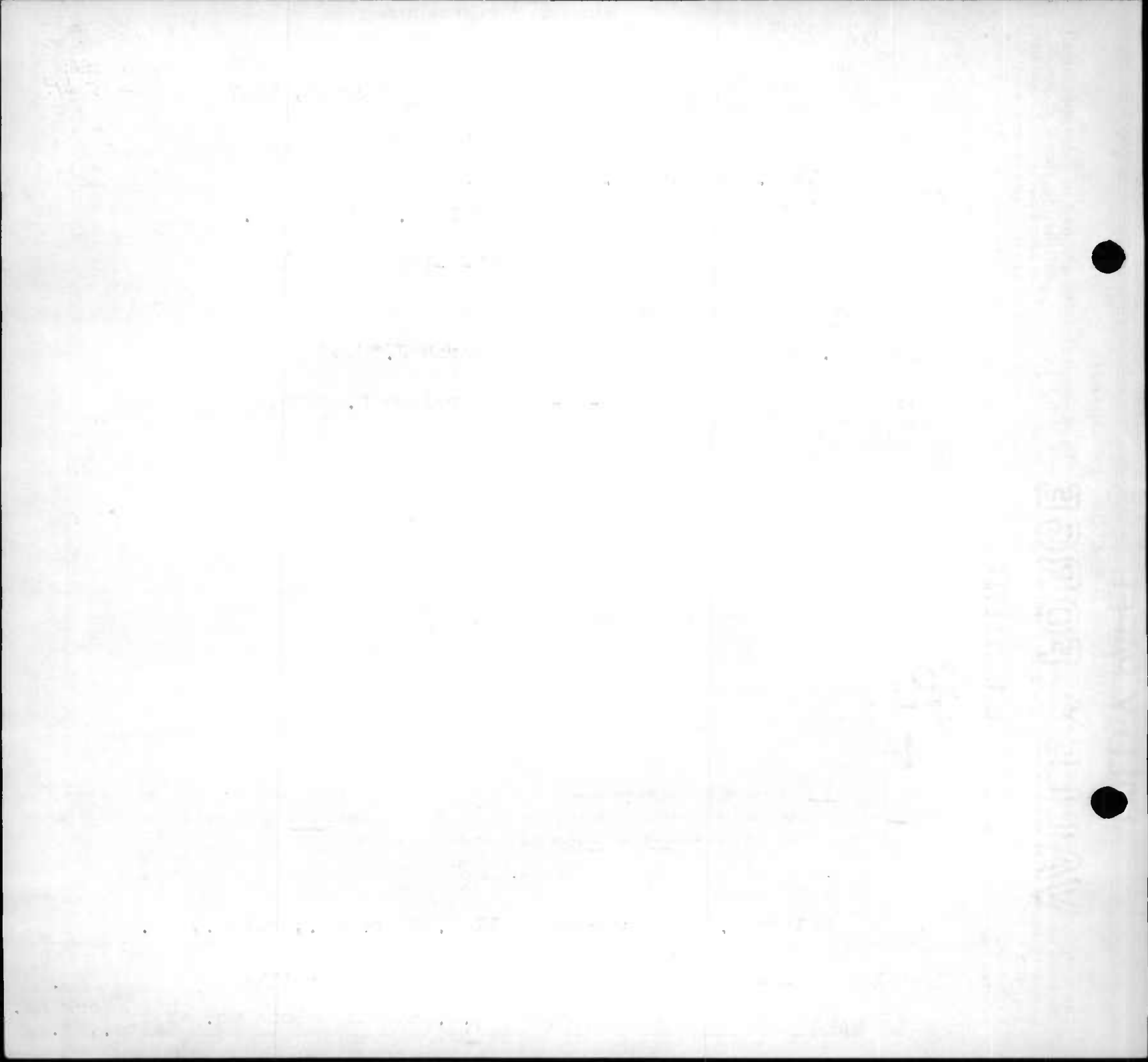
Church Home and Hospital
Mar 6, 1912

Alfred T. Cox
Ref T. C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

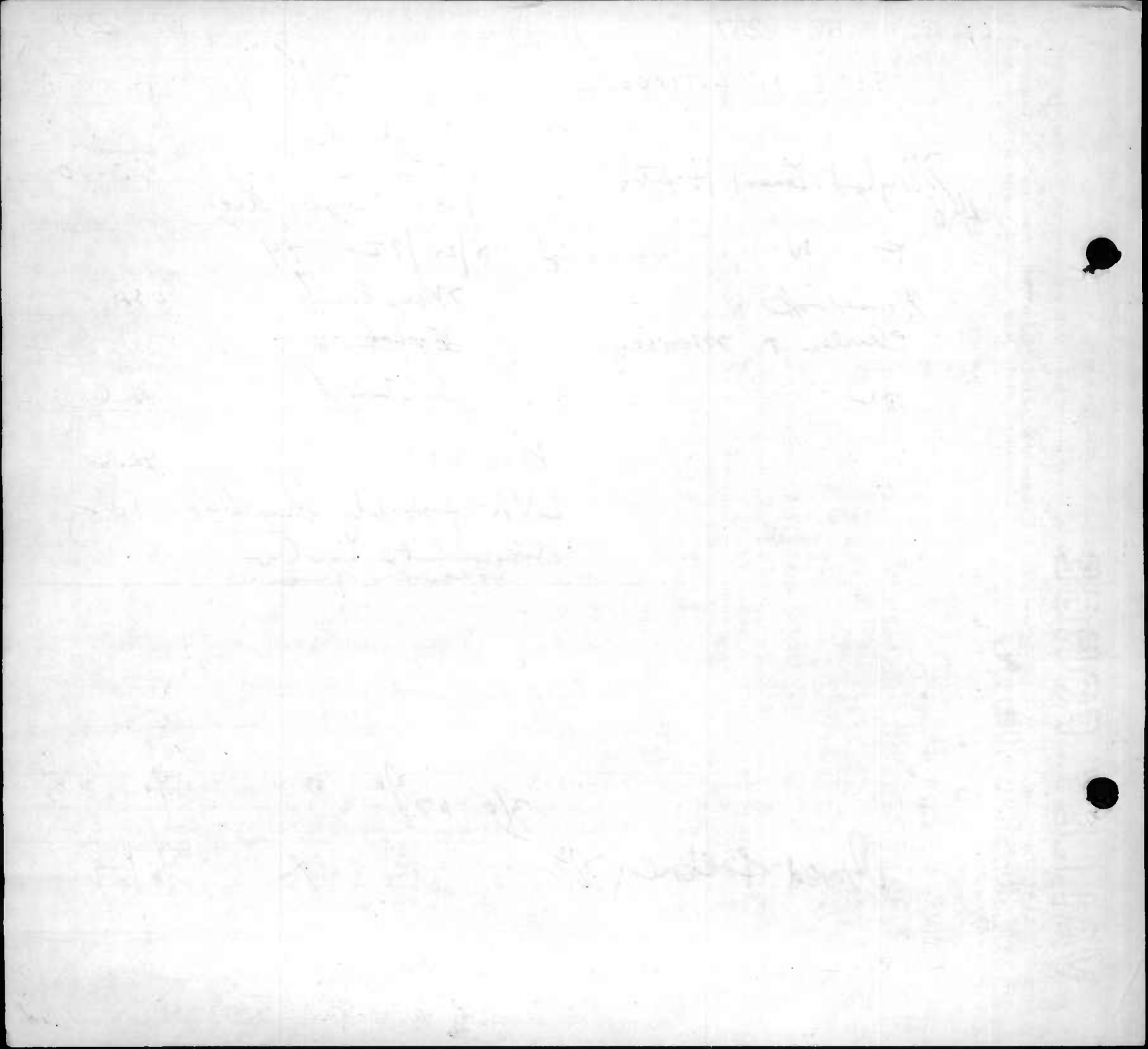
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2256 | |
|---|---------------------|---|--|---|--|
| BIRTH NO. 67 2256 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | BERTHA CHAPIN STIRES | | March 6, 1967 approximately 12:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2919 N. Calvert St. | | | A. STATE Maryland | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 2919 N. Calvert St. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 11-6-1885 | 9. AGE (In years last birthday) 81 | 10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) Nebraska | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Charles E. Chapin | | | 14. MOTHER'S MAIDEN NAME Sarah J. Wood | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 216-46-3616 | 17. INFORMANT Harrison L. Stires | | ADDRESS Above |
| 18. 4-22-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Myocarditis - arterosclerosis DUE TO myocardial infarct. (B) arterosclerosis, generalized DUE TO yes. (C) none. | | INTERVAL BETWEEN ONSET AND DEATH 1 week yes. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1946 to March 6 19 67 , that (I) (we) last saw the deceased alive on Dec. 2 19 66 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Walter L. Winkenwerder | | | 23B. DATE SIGNED 3/7/67 | | |
| 23C. PHYSICIAN'S NAME (Type) Walter L. Winkenwerder | | | 23D. ADDRESS 11 E. Chase St., Balto., Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-9-67 | | 24C. NAME of CEMETERY or CREMATORY Druid Ridge | |
| | | | | 24D. LOCATION (City, town, or county) (State) Pikesville Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | |
| | | | | ADDRESS 4905 York Rd. Balto., Md. | |



FUNERAL DIRECTOR: IMPORTANT

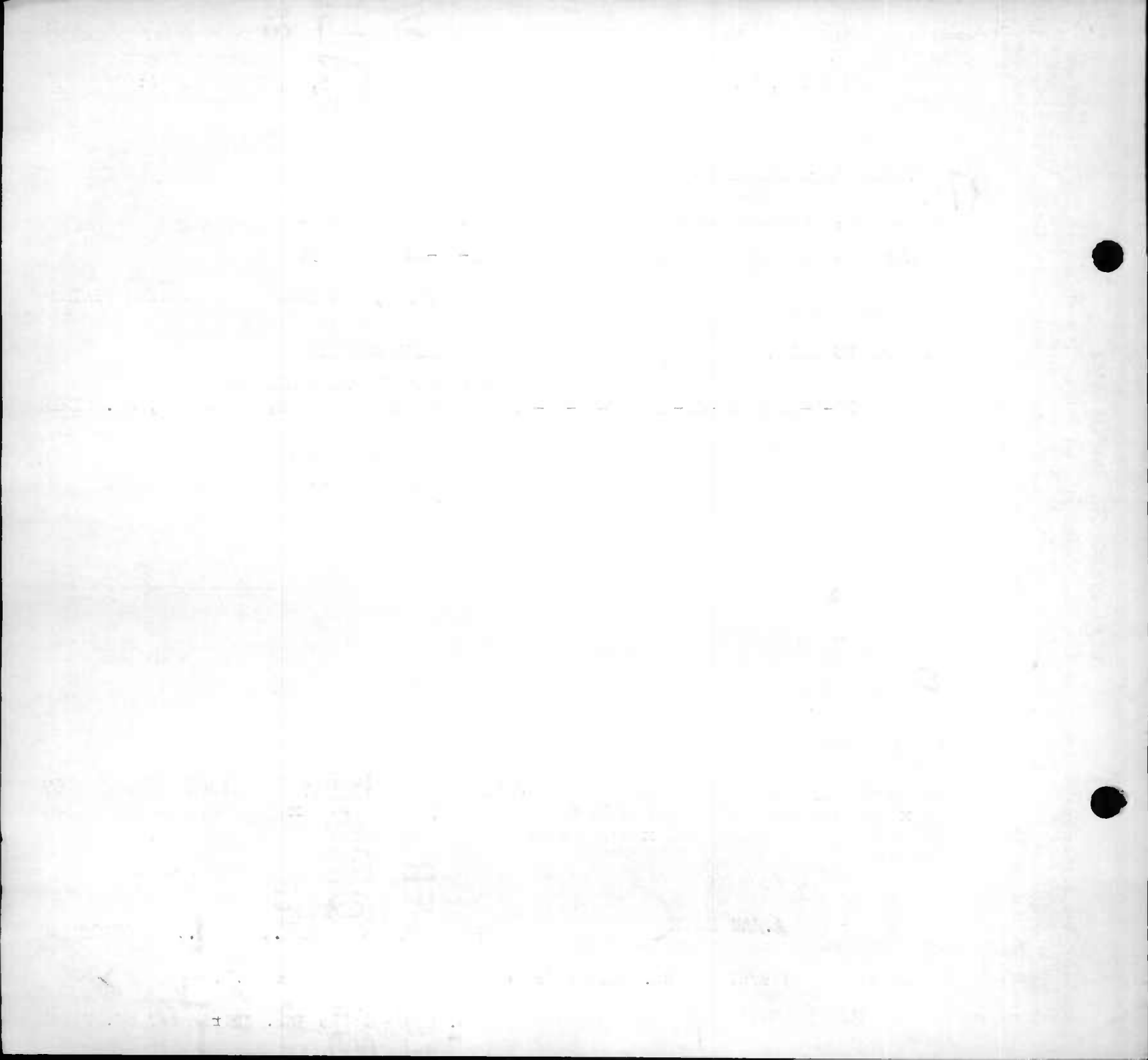
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-------------------------|---|------------------------------------|--|---|
| BIRTH NO. 67 2257 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2257 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>ELSIE M. LUTTRELL</u> | | 2. DATE AND HOUR OF DEATH <u>3/6/67</u> <u>12:15</u> P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> (34) <u>53-00</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>1305 Taylor Ave.</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>5/25/92</u> | 9. AGE (In years last birthday) <u>74</u> | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Home -</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Charles T. Maxley</u> | | 14. MOTHER'S MAIDEN NAME <u>Susan Iglehart</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>212-18-0164</u> | | 17. INFORMANT <u>George E. Luttrell</u> ADDRESS <u>For Cash 4</u> | |
| 18. <u>422.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ASCVD</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <u>years</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CVA - probably beriberi</u> <u>Arteriosclerotic Cardiovascular disease</u> | | (A) DUE TO | | (B) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/6</u> 19 <u>67</u> to <u>3/6</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/6</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>James J. Lohney</u> M.D. | | | | 23B. DATE SIGNED <u>3/6/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>MAR 9 1967</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>London Park Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 7 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Lohney</u> | |
| 25C. FUNERAL DIRECTOR <u>McCarte-Brooks Towson</u> | | 25D. ADDRESS <u>1032 York Rd. Towson 4, Md</u> | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-----------------------------|---|---|---|---|
| BIRTH NO. 67 2258 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 67 2258 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MC QUADE, FRANCIS HOWARD | | | 2. DATE AND HOUR OF DEATH MARCH 6, 1967 4:50 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD BALTIMORE, MARYLAND 21218 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, give RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2712 HURON STREET | | |
| 5. SEX Male | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 3-18-10 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIEF STEVEDORE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) WATERVLIET, NEW YORK | |
| 13. FATHER'S NAME MICHAEL MC QUADE | | | 14. MOTHER'S MAIDEN NAME ALICE AUDETTE | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES | | 16. SOCIAL SECURITY NO. 10-9-42 to 10-10-43 065-30-90-17 | | 17. INFORMANT VETERANS HOSPITAL RECORDS ADDRESS 3900 LOCH RAVEN BLVD, BALTIMORE, MD. 21218 | |
| 18. 193.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Adenocarcinoma to brain DUE TO primary site unknown ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from JANUARY 2 19 67 to MARCH 6 19 67 , that (1) (we) last saw the deceased alive on MARCH 6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>A. Jay Block</i> | | | | 23B. DATE SIGNED 3/7/67 | |
| 23C. PHYSICIAN'S NAME (Type) A. JAY BLOCK | | 23D. ADDRESS M.D. VA HOSPITAL 3900 Loch Raven Blvd., Balto., Md 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3/9/67 | 24C. NAME OF CEMETERY or CREMATORY St. Patrick's Cem | | 24D. LOCATION (City, town, or county) (State) Colonie, N.Y. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR Wm. Cook Brooks Inc. Baltimore, Md. 21202 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2259 | |
|---|-------------------------|--|-------------------------------------|--|---|
| BIRTH NO. 67 2259 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Missouri Dawson | | 2. DATE AND HOUR OF DEATH 3/3/67 2:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 2 | | | |
| D. STREET ADDRESS (If rural, give location) 1712 HOLBROOK ST. | | 9-09 | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 3-3-1903 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Business | | 11. BIRTHPLACE (State or foreign country) Charleston, S.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME SAMUEL MIDDLETON | | | |
| 14. MOTHER'S MAIDEN NAME ROSA WRIGHT | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Evelyn McCants 1712 Holbrook St. | | | |
| 18. 43301 | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest | | (A) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO ASCVD | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/3 19 67 to 3/3 19 67 , that (I) (we) last saw the deceased alive on 3/3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Kenneth Brigham</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/3/67 | |
| 23C. PHYSICIAN'S NAME (Type) Kenneth Brigham | | 23D. ADDRESS M.D. Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-8-67 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS Marshall W. Jones, Jr. 1735 Harford Avenue | |

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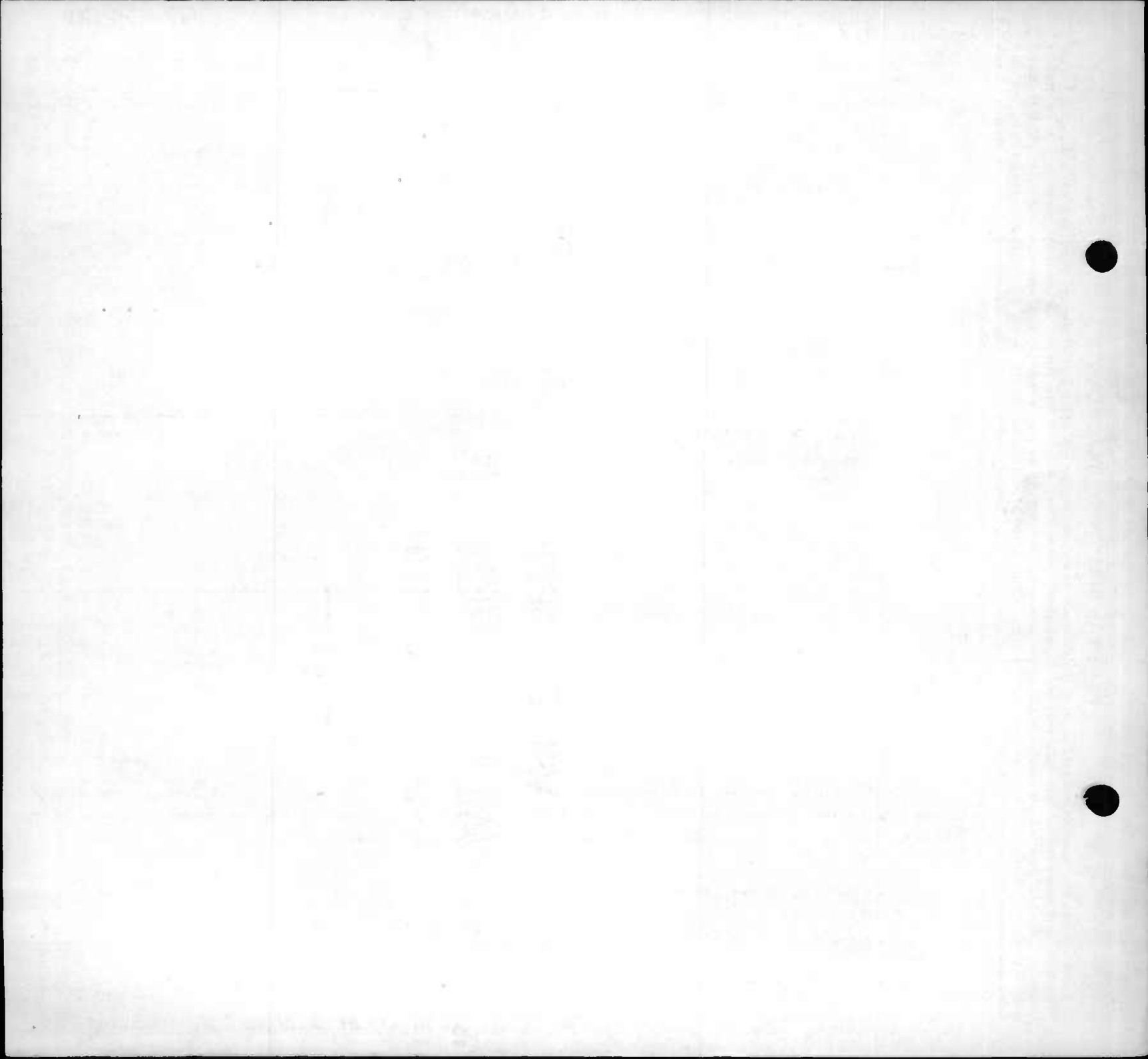
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|---------------------------|---|---|--|---|
| BIRTH NO. 67 2260 | | CERTIFICATE OF DEATH | | 67 2260 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Nancy Elizabeth Robinson | | | 2. DATE AND HOUR OF DEATH 3-5-67 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 808 Whitelock Street | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. D. STREET ADDRESS (If rural, give location) 808 Whitelock St. | | |
| 5. SEX F | 6. RACE Negroid | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 5-3-94 | 9. AGE (In years last birthday) 72. | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME Frank Robinson | | | 14. MOTHER'S MAIDEN NAME Mary | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 124140669 | | 17. INFORMANT John Robinson 808 Whitelock St. | |
| 18. 4721-260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Branchial Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. BRONCHITIS PHARYNGITIS II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 1960 to March 4, 1967 , that (I) (we) last saw the deceased alive on March 4, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jesse T. Holmes | | | | 23B. DATE SIGNED 4/6/67 | |
| 23C. PHYSICIAN'S NAME (Type) Jesse T. Holmes | | 23D. ADDRESS 508 E North Ave. BALT. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-9-67 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem. | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

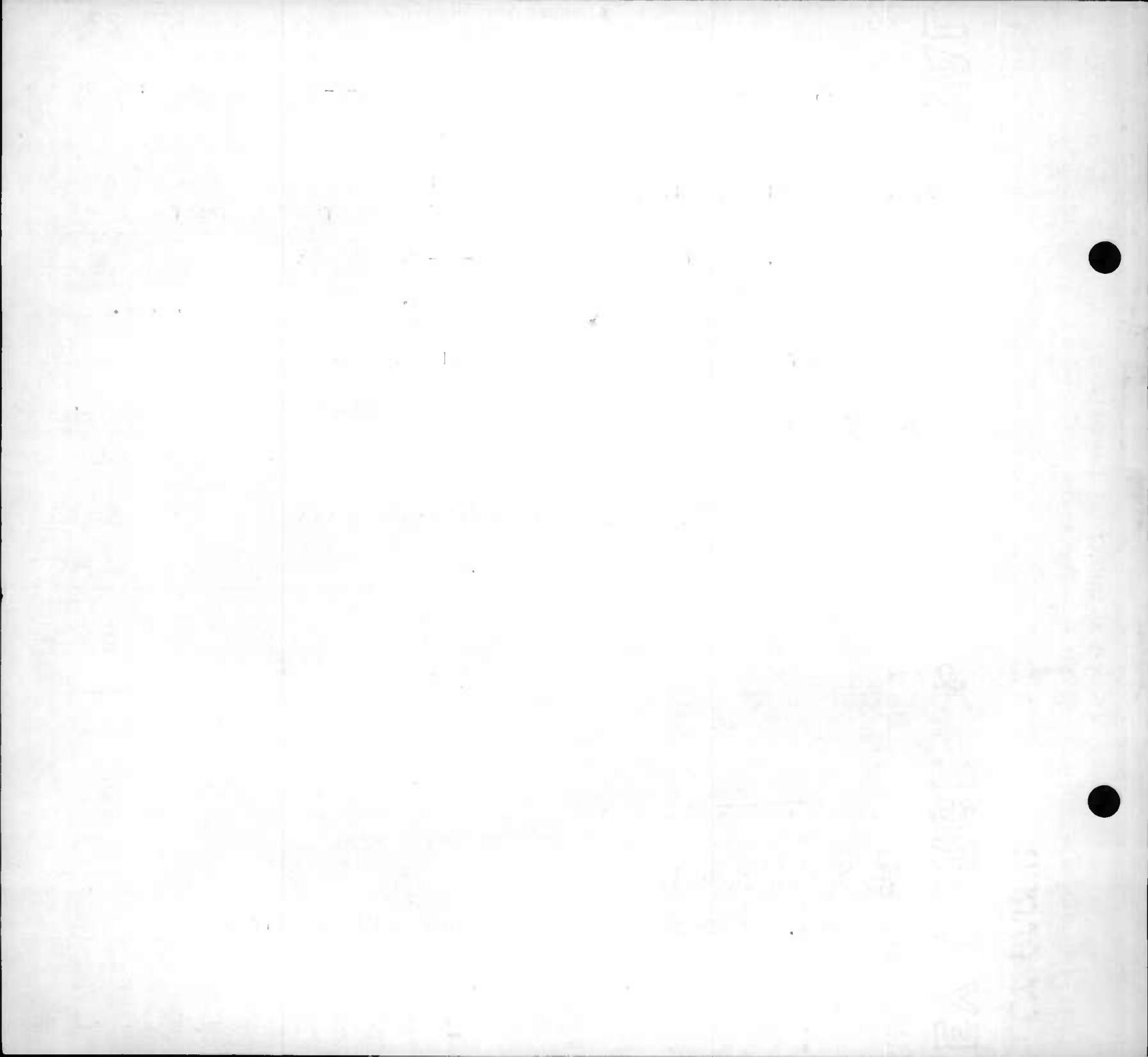
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2261 | |
|---|---------------------------|--|-------------------------------------|---|---|
| BIRTH NO. 67 2261 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Theodore R. Ricks | | 2. DATE AND HOUR OF DEATH 3-5-67 (3-5-67) 3:40 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION CERTIFICATE AMENDED 912 Harlem Ave. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 912 Harlem Ave. | | | |
| 5. SEX Male | 6. RACE Negroid | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 10-28-02 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Va. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME John Rickes | | 14. MOTHER'S MAIDEN NAME Julia | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Alice Ricks ADDRESS 912 Harlem Ave. | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute CORONARY DISEASE CORONARY THROMBOSIS ARTERIOSCLEROSIS (Generalized) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 3-3-67 to 3-35-67 , that (I) (we) last saw the deceased alive on 3/35 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE G. L. BANYFIELD | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/6/67 | |
| 23C. PHYSICIAN'S NAME (Type) G. L. BANYFIELD | | M.D. 23D. ADDRESS 722 N. Fulton Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-8-67 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR MAR 7 1967 | |
| 25C. FUNERAL DIRECTOR Kelson Funeral Home-1348 N. Calhoun St | | ADDRESS | | | |

3/14/67- Letter from Dr. Gilbert S. Sanford.
~~Patient~~ Pronounced lifeless on 3/5/67. JPC.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2262 | |
|---|------------------------|---|------------------------------------|---|---|
| BIRTH NO. 67 2262 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) HOLT, EDWARD | | 2. DATE AND HOUR OF DEATH 3-5-67 8:14 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1026 NORTH STOCKTON STREET | | | |
| 5. SEX M | 6. RACE COL. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER | 8. DATE OF BIRTH 1-16-84 | 9. AGE (In years last birthday) 82 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S./A. | | 13. FATHER'S NAME EDWARD HOLT | | 14. MOTHER'S MAIDEN NAME ELIZA THOMAS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214207981 | | 17. INFORMANT Lucille Mundy ADDRESS 1026 Stockton St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASPIRATION | | INTERVAL BETWEEN ONSET AND DEATH 10 minutes | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Intestinal Obstruction | | DUE TO 56 hours | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 2 19 67 to March 5 19 67 , that (I) was lost saw the deceased alive on March 5 19 67 and that in (my) our my opinion death occurred on the date and hour and from the causes stated above. (I) was did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert A. Ratcheson | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED March 5, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT A. RATCHESON | | 23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-8-67 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | | |
| 25B. NAME OF REGISTRAR Robert A. Ratcheson | | 25C. FUNERAL DIRECTOR Johnson Funeral Home-1348 N. Calhoun | | | |



B-300

67 2263

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2263

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) GENEVA BETHEA 2. DATE AND HOUR PRONOUNCED DEAD 3-5-67 9:50 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46/99 LUTHERAN HOSPITAL - DOA

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1909 Harlem Avenue

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

10-23-02

9. AGE (In years last birthday)

64

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Higgins

14. MOTHER'S MAIDEN NAME

Joanna Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Leota Grade 1909 Harlem Ave.

18. E 816.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of cervical vertebra with contusion of spinal cord

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Braddish Avenue and Winchester Street

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)

3 5 '67 9:30 PM

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto-auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-6-67

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

3-10-67

23C. NAME of CEMETERY or CREMATORY

Church Cem.

23D. LOCATION

(City, town, or county)

(State)

Franklin, North Carolina

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 7 1967

Kelson Funeral Home-1348 Calhoun St.

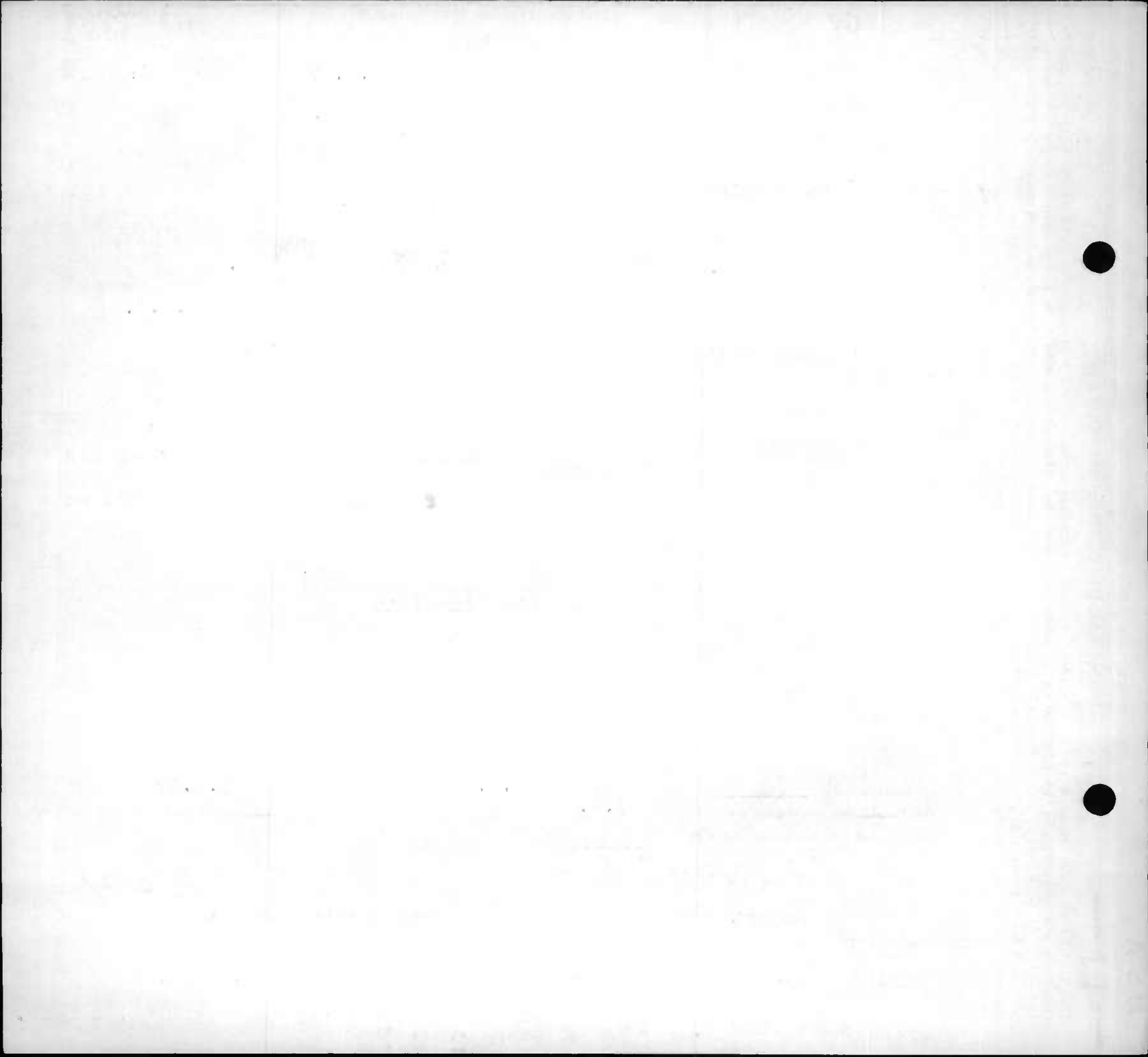
MAILEY PROFILES

20/11/1971

1/11/1971

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2264 | |
|--|---------------------|--|---|--|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 2264 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) Dale Williams | | | 2. DATE AND HOUR OF DEATH 3.6.67 2:30 PM | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital | | | A. STATE Maryland | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 2204 Roslyn Avenue | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 8/13/43 | 9. AGE (In years) lost to 25 23 yrs. | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Gilford Williams | | | 14. MOTHER'S MAIDEN NAME Vashti Valentine | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Vashti Brooks 2204 Roslyn Ave/ | |
| 18. 340.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Sepsis | | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | 1B) DUE TO Meningitis | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | 1C) DUE TO Chronic Sinusitis | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from 3.4.67 19 to 3.6.67 19, that (I) (<u>we</u>) last saw the deceased alive on 3.6.67 19 and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert M. Winslow | | | 23B. DATE SIGNED 3/6/67 | | |
| 23C. PHYSICIAN'S NAME (Type) Robert M Winslow | | | 23D. ADDRESS Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-9-67 | | 24C. NAME OF CEMETERY or CREMATORY New Catharal Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robt E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS Kelson Funeral Home 1348 Calhoun St. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-----------------------------|--|-------------------------------------|--|---|
| BIRTH NO. 67 2265 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2265 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) VANDERFORD, S. JAMES | | 2. DATE AND HOUR OF DEATH 3/3/67 9:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) George Washington Nursing Home 607 Pennsylvania Ave. | | A. STATE Baltimore, Md. B. COUNTY Montebello Hospital C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Md. D. STREET ADDRESS (If rural, give location) 3439 Patuxent Ave | | | |
| 5. SEX Male | 6. RACE Negro. | 7. MARRIED, NEVER MARRIED, WIDOWED, <u>DIVORCED</u> (specify) | 8. DATE OF BIRTH 8-9-1911 | 9. AGE (In years last birthday) 47 | 10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALT. Md. | |
| 13. FATHER'S NAME John Vanderford | | 14. MOTHER'S MAIDEN NAME DORA JARVIS | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT CHART. | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Acute Coronary Thrombosis (B) Left Cerebral Thrombosis (C) Atherosclerotic Heart Dis. | | INTERVAL BETWEEN ONSET AND DEATH 3-4 hrs. 1965 Unknown | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Right Hemiplegia & Aphasia | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/15 19 66 to 3/3 19 67 , that (I) (we) last saw the deceased alive on 3/1 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE E.E. Holt | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/3/67 | |
| 23C. PHYSICIAN'S NAME (Type) F.E. Holt | | 23D. ADDRESS M.D. 3715 Liberty Hts Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3-26-67 | 24C. NAME OF CEMETERY OR CREMATORY Mt Antawn Cent | | 24D. LOCATION (City, town, or county) (State) Balto Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR Robert E. Jackson | | 25C. FUNERAL DIRECTOR Chas. O. Wilson | |
| | | | | ADDRESS 1000 Bunting Ave | |

Boyle m

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2266 | |
|--|-------------------|---|------------------------------|--|----------------------------------|
| BIRTH NO. 67-22811 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Clowney, AthLee | | 2. DATE AND HOUR OF DEATH 3-6-67 9 40 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 2506 Preston St | | | |
| 5. SEX C Negro | 6. RACE M Male | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Child | 8. DATE OF BIRTH 10-24-66 | 9. AGE (In years last birthday) XXX | 10. Under 1 Yr. Months Days 4 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore Md | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME Nancy Clowney | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Nancy Clowney | |
| 18. 73-4,11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CONGENITAL HEART DEFECTS - PDA + VSD Mongolism. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 3/6/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Patent ductus + VSD | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 3/5 1967 to 3/6 1967, that (1) (we) last saw the deceased alive on 3/6 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R. L. Hurwitz M.D. | | | | 23B. DATE SIGNED 3/6/67 | |
| 23C. PHYSICIAN'S NAME (Type) Richard L Hurwitz M.D. | | | | 23D. ADDRESS The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-8-67 | | 24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cml | |
| 24D. LOCATION (City, town, or county) (State) Brooklyn Md | | 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR Philip E. Jackson | |
| | | 25C. FUNERAL DIRECTOR Cheryl Wilson | | 25D. ADDRESS 1001 Brantley Rd | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|-------------------------|--|---|--|---|--|--|---|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>67 2267</u> | | | | | |
| BIRTH NO. <u>67 2267</u> | | | | | M.E. CASE NO. <u>67 2267</u> | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>ALVERTA THOMPSON (McDonald)</u> | | | | | 2. DATE AND HOUR OF DEATH <u>3/3/67</u> <u>945</u> <u>P</u> M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 JOHNS HOPKINS HOSPITAL.</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>8-06</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE, 13</u> D. STREET ADDRESS (If rural, give location) <u>1614 REGENER ST.</u> | | | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>6-30-1894</u> | 9. AGE (In years last birthday) <u>72</u> | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign county) <u>A.A. County Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>ROBERT MCDONALD</u> | | | 14. MOTHER'S MAIDEN NAME <u>MARY E. OWENS</u> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Wayward Thompson Same</u> | | | | | |
| 18. <u>199.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Hypertension</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>? pulm. emboli</u> <u>Carcinoma - site unknown</u> | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>3/2</u> 19 <u>67</u> to <u>3/3</u> 19 <u>67</u> , that <u>(I)</u> (we) last saw the deceased alive on <u>3/3</u> 19 <u>67</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) <u>(did)</u> (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <u>F. Ismail Beigi</u> | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>3/3/67</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>F. Ismail Beigi</u> | | | | | | 23D. ADDRESS M.D. <u>The Johns Hopkins Hospital</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>3-8-67</u> | | | 24C. NAME OF CEMETERY or CREMATORY <u>Greenwood</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Lanham Md</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 7 1967</u> | | | 25B. NAME OF REGISTRAR <u>Dr. J. E. Taylor</u> | | | 25C. FUNERAL DIRECTOR <u>Shog Wilson 1000 Brantley</u> | | | ADDRESS | |

9-21

1-2-18

10-2-18

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1-2-18

1-2-18

1-2-18

1-2-18

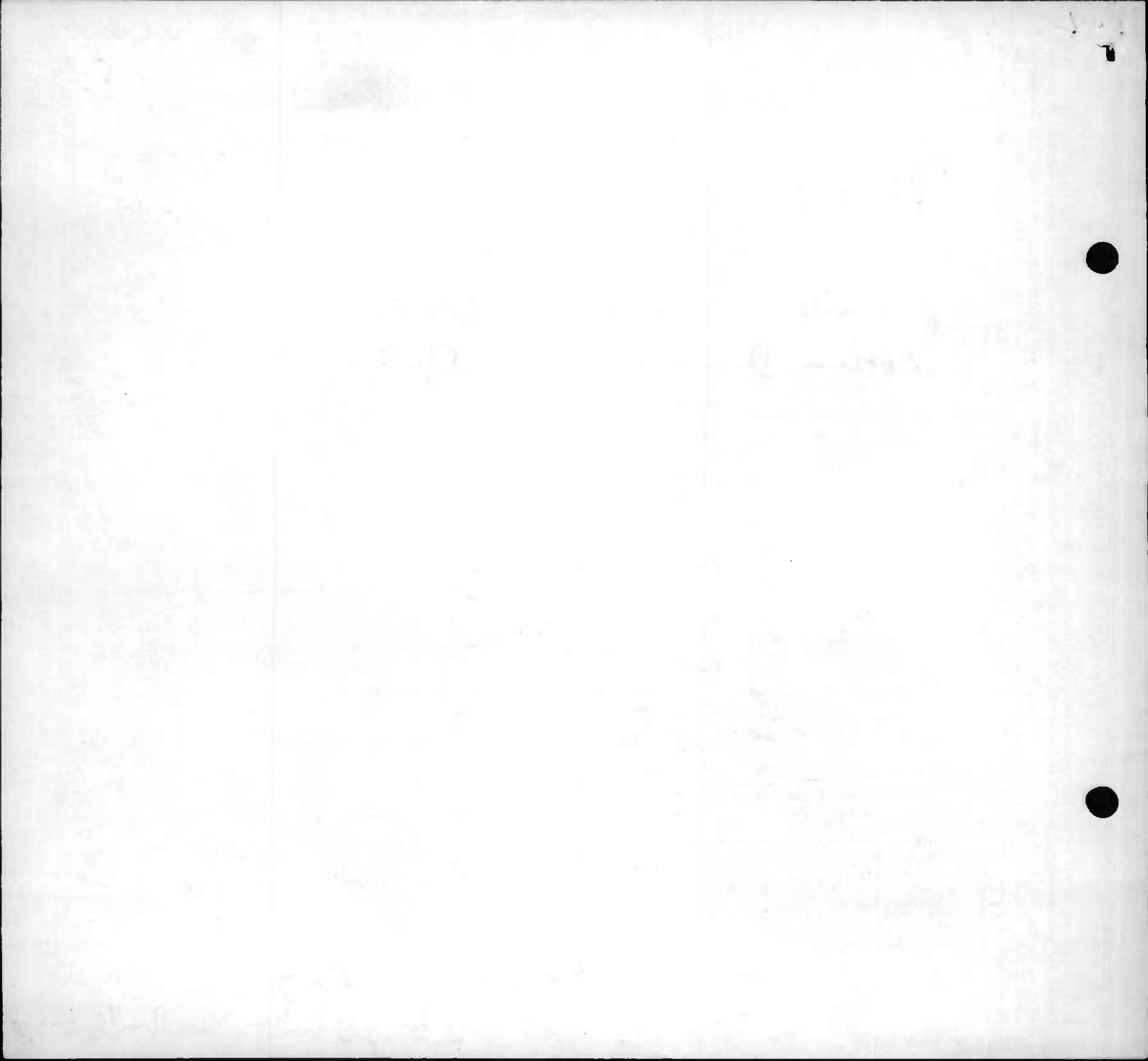
1-2-18

1-2-18

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2268 | |
|--|------------------|---|-----------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 2268 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) Gillespie - Lillie | | 2. DATE AND HOUR OF DEATH 2/28/67 3:00 p.m. P. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Dulakand Nursing Home 90 1501 Dulakand Street | | A. STATE B. COUNTY Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 402 | | | |
| | | D. STREET ADDRESS (If rural, give location) 205 n. Fremont Apt. 5 | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 9/18/87 | 9. AGE (In years last birthday) 76 | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Edenton N.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Abraham B. B. B. | | 14. MOTHER'S MAIDEN NAME Bettie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Dulakand nursing Home | |
| 18. 420.0 I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO Congestive Failure | | 7 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Arteriosclerotic Hrt Disease | | | |
| (C) _____ | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Percival C. Smith | | | | 23B. DATE SIGNED 2-28-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-4-67 | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn C. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 25B. NAME OF REGISTRAR R. B. E. Fairbank | | 25C. FUNERAL DIRECTOR Shirley B. Wilson | |
| | | | | ADDRESS 1000 B. B. B. B. | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RAYMOND

RAYMOND

GOINS

2. DATE AND HOUR PRONOUNCED DEAD

3-6-67 3/5/67 11:45 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
HOSPITAL OR INSTITUTION

2115 Southern Avenue - Amb. Crew #6

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2115 Southern Avenue 21214

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

12/22

72-22-1919

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Bulwark

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Amos Goins

14. MOTHER'S MAIDEN NAME

Minnie Wade

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Marie Goins

ADDRESS

Lanham

18.

443X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic and hypertensive
cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

3-6-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-9-67

23C. NAME OF CEMETERY or CREMATORY

Catholics Ave

23D. LOCATION

Lanham

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 7 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Eloy O. Wilson 1000 Brantley Ave

ADDRESS

3/14/67 - Letter from Office of the Chief Medical Examiner, 700 Fleet Street, dated 3/14/67.

Change in spelling of given name from RYAMOND to "RAYMOND". Date of death changed from 3/6/67 to 3/5/67. Signed by S. Small, Sec. to Werner U. Spitz, Md. Asst. Medical Examiner. Birth date changed from 12/27 to 12/22/1919. Certificate of birth for deceased. Raymond Goins, B.D. 12/22/1919 - Halifax County, N.C.

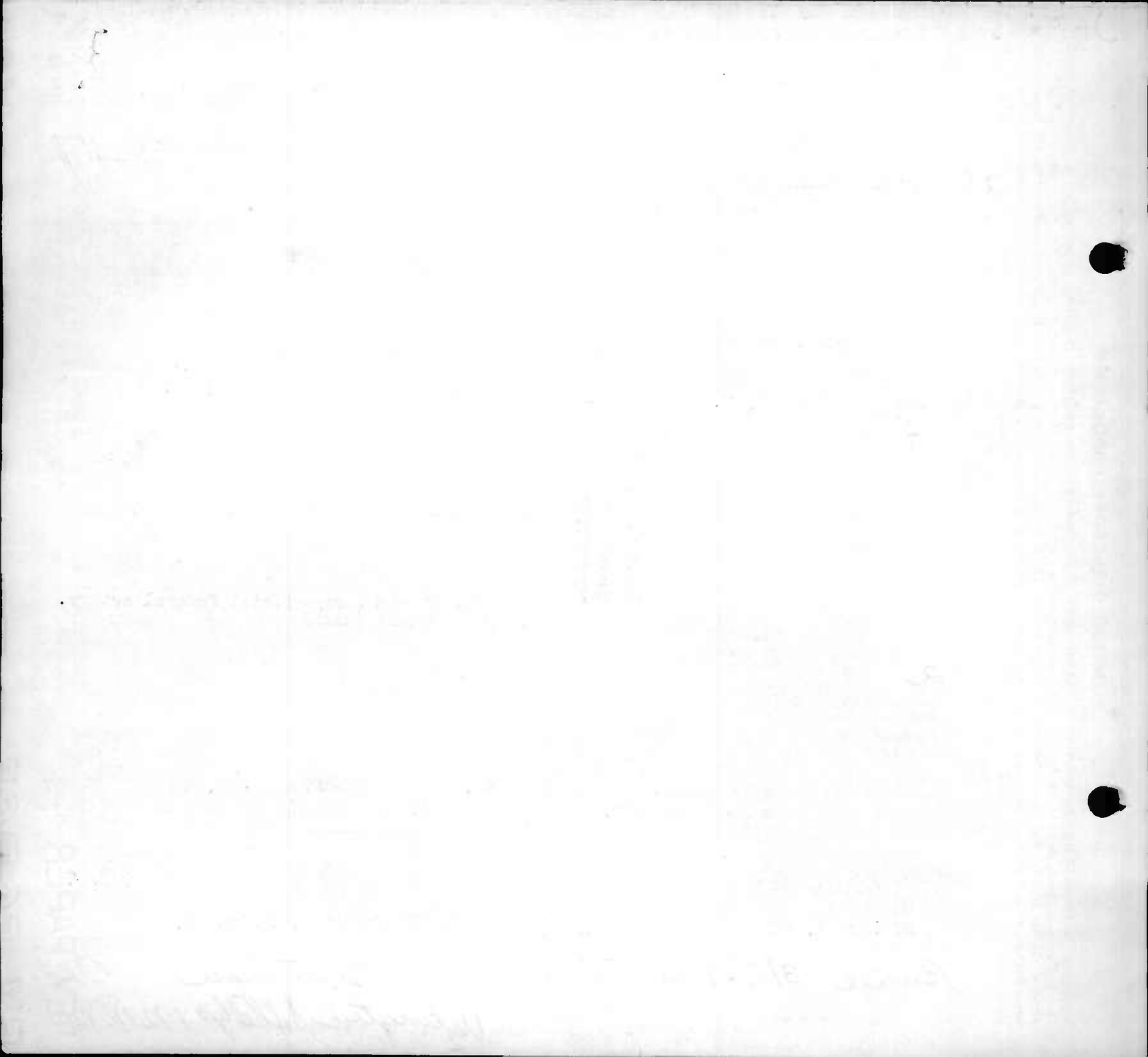
Reg. #42-5539 - Cert. #3.

J. B. Carter

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

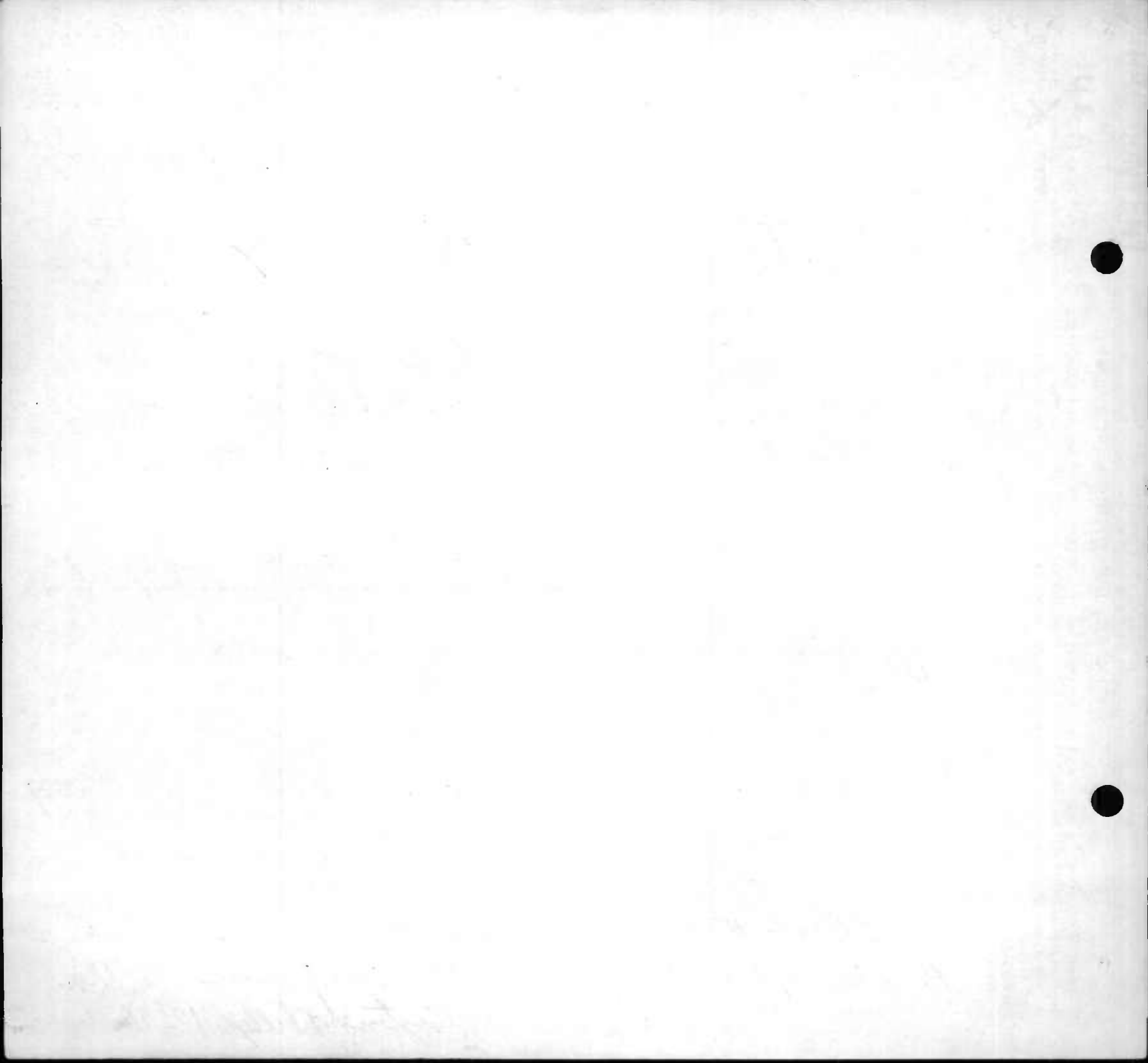
| TO BE APPROVED BY BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 2270 | |
|--|-----------------------|--|---|--|--|
| BIRTH NO. MEDICAL EXAMINER 2270 | | | | Certificate of Death | |
| M.E. CASE NO. | | | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) Leslie Johnson | | | 2. DATE AND HOUR OF DEATH Mar. 2, 1967 10 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-47 D. STREET ADDRESS (If rural, give location) 3306 Windsor Ave. | | |
| 5. SEX M | 6. RACE Col | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 6/22/98 | 9. AGE (In years lost birthday) 68 | If Under 1 Yr. Months: Ooys: Hours: Min. If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Ky. | |
| 13. FATHER'S NAME Charlie Johnson | | | 14. MOTHER'S MAIDEN NAME Sarah Robertson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USA 30 yrs. | | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute pulmonary edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardiovascular disease | | | CAUSE OF DEATH Thrombus of right superficial femoral artery. Hemolytic anemia (clinical) | | |
| 19A. DATE OF OPERATION 2 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I/this hospital) attended the deceased from Feb. 15 19 67 to Mar. 2 19 67 , that (I/we) last saw the deceased alive on Mar. 2 19 67 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael E Pelczar M.D. | | | | 23B. DATE SIGNED 3/3/67 | |
| 23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, SA Surgeon (R) M.D. | | | | 23D. ADDRESS US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/7/67 | | 24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | | |
| 25B. NAME OF REGISTRAR Ashton S. Phillips | | 25C. FUNERAL DIRECTOR ADDRESS 1727 N. Monaca | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

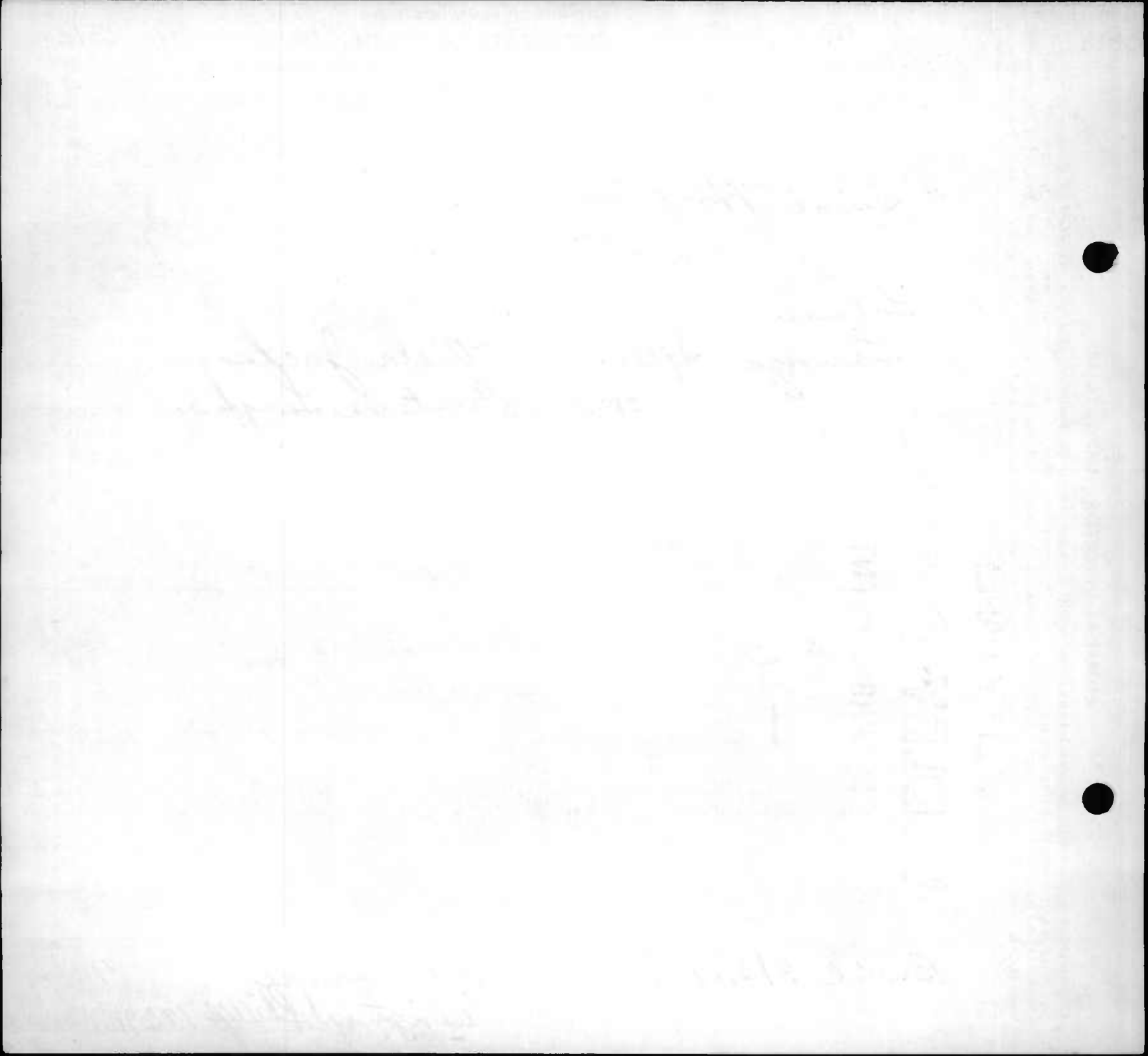
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|--|--|--|--|--|
| 67 2271 | | CERTIFICATE OF DEATH | | 810 2819 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | STINSON, Hugh Benton | | 3/5/67 11:30 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| Franklin Square Hospital | | MD | | BALTIMORE | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER/MARRIED WIDOWED, DIVORCED (specify) | |
| M | | C | | M | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Store Keeper | | | | N.C. Holly Springs | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Ferman STINSON | | Maggie Pigham | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | THERESA STINSON 233-7857 | |
| 18. 331 X I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) C. V. A. (Rt hemisphere) | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | DUE TO | | | |
| ANTECEDENT CAUSES | | (B) Uremia | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO | | | |
| | | (C) Pneumonia | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | 2/13 1967 to | | 3/5 1967 | |
| that (I) (we) last saw the deceased alive on | | 3/5 1967 | | and that in (my) (our) opinion death occurred on the date | |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Chang Kue Kim M.D. | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Chang Kue Kim M.D. | | Franklin Square Hospital | | Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3/9/67 | | Archives Mmsh. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAR 7 1967 | | P. B. E. Talbott | | Wilmington Phillips 1727 N. Mowbray St | |



FUNERAL DIRECTOR: IMPORTANT

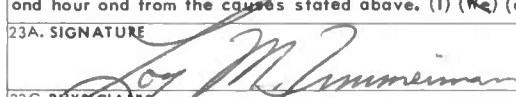
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

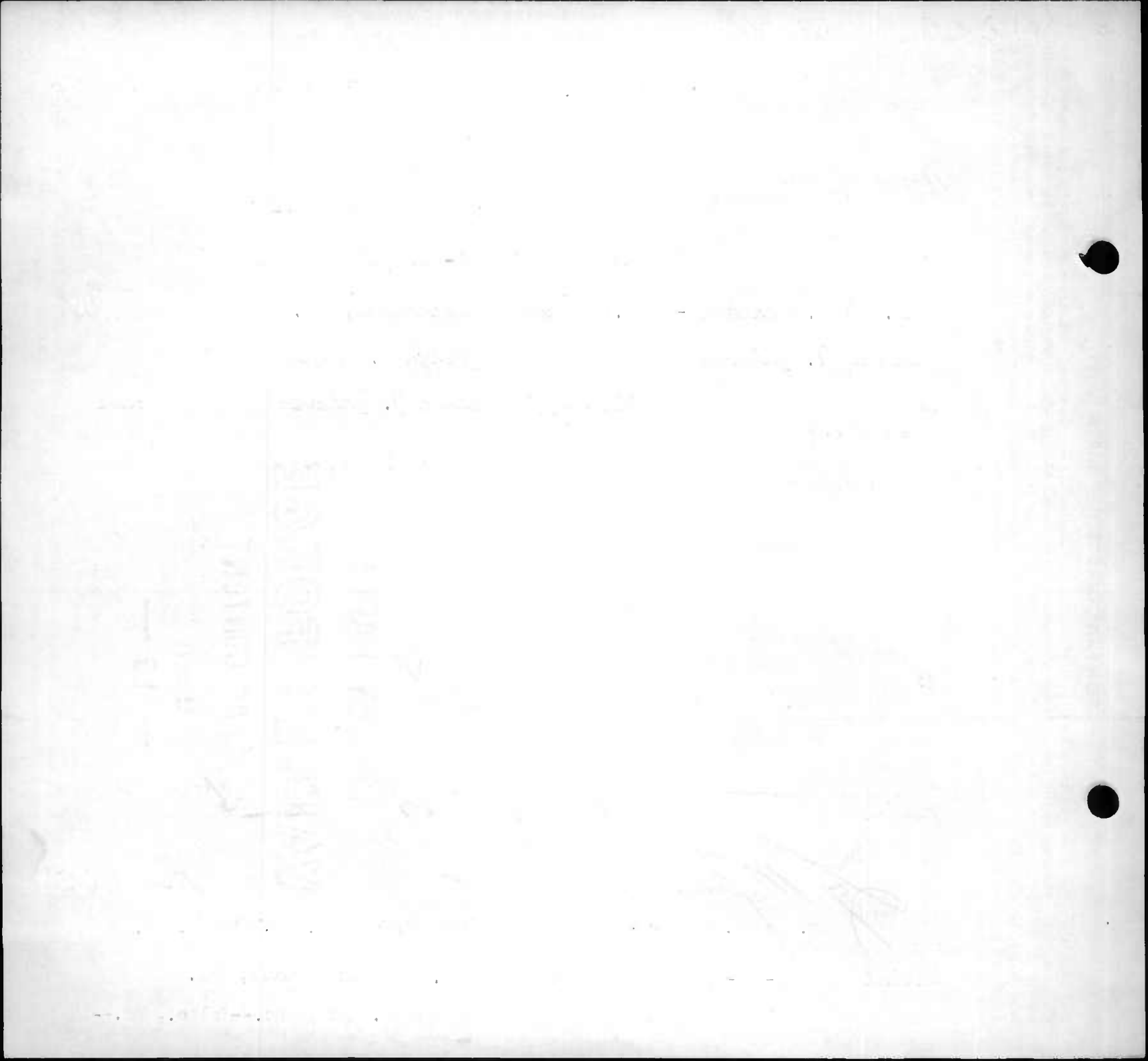
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2272</u> | |
|--|---------------------|---|------------------------------------|--|---|
| BIRTH NO. <u>67 2272</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>SPELL CLIFTON</u> | | 2. DATE AND HOUR OF DEATH <u>3/2/67</u> <u>1:20 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>H2 Sinai Hospital</u> | | A. STATE <u>MD</u> B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>16-05</u> | |
| | | D. STREET ADDRESS (If rural, give location) <u>2545 ARUNAH AVE</u> | | | |
| 5. SEX <u>♂</u> | 6. RACE <u>N</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>8-26-18</u> | 9. AGE (In years last birthday) <u>48</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>Lorenzo Spell</u> | | 14. MOTHER'S MAIDEN NAME <u>Viola Jackson</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>218-05-0973</u> | | 17. INFORMANT <u>Constance Langford</u> ADDRESS <u>25-39 Seaman ave.</u> | |
| 18. <u>163X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Ca lung</u> | | CAUSE OF DEATH (A) _____ DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>? XR</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> 19 <u>67</u> to <u>3/2</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/2</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Stephen Gordon</u> M.O. | | | | 23B. DATE SIGNED <u>3/2/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Stephen Gordon</u> | | | | 23D. ADDRESS <u>M.D.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/6/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Crown Mem. Pk. Laurel</u> | |
| 24D. LOCATION <u>MD.</u> | | 25A. DATE RECEIVED BY HEALTH DEPT. <u>MAR 7 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Phillips</u> | |
| 25C. FUNERAL DIRECTOR <u>Robert E. Phillips</u> | | 25D. ADDRESS <u>1727 N. Mount St.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

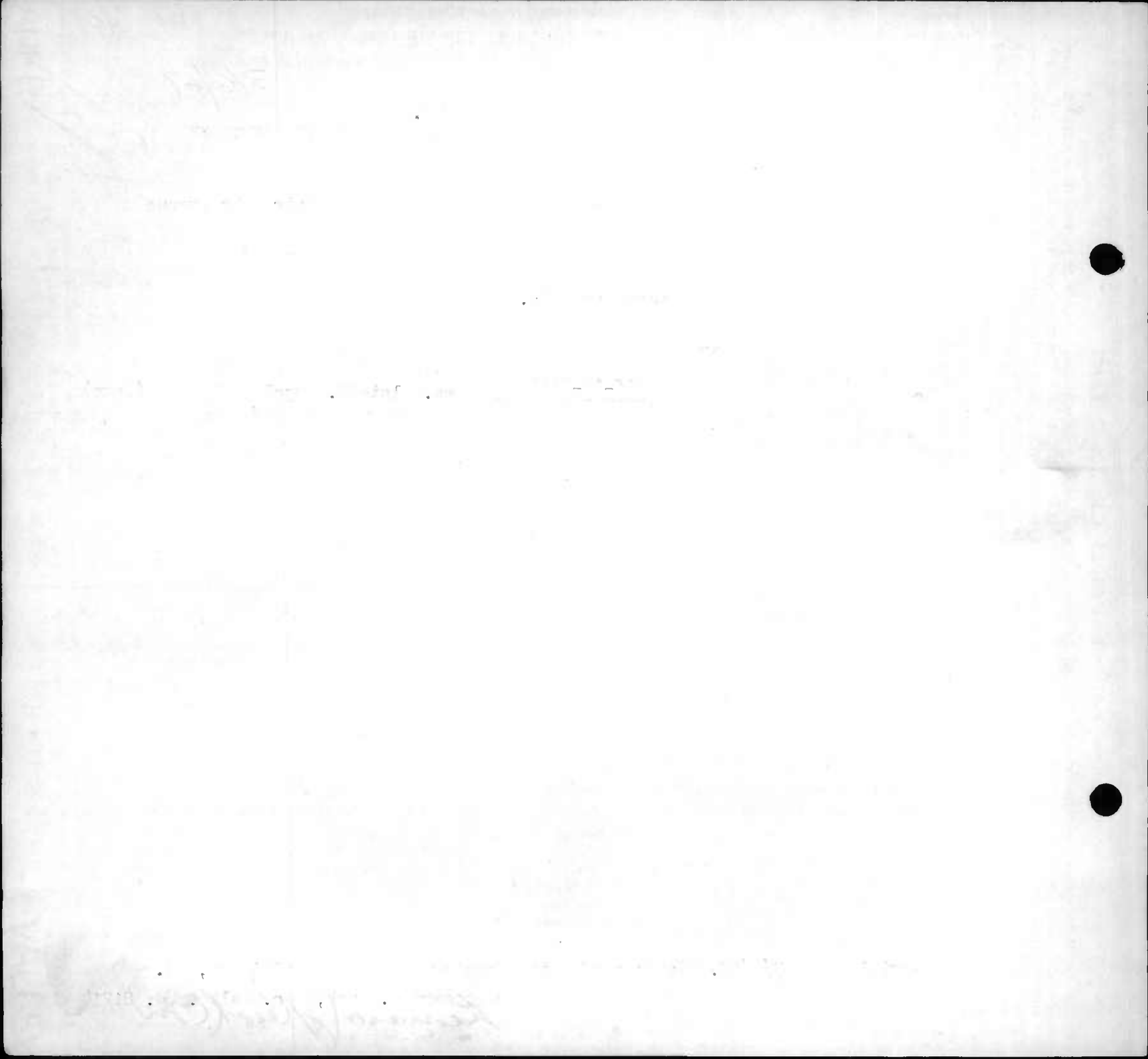
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | | Registered No. 67 2273 | |
|--|-------------------------|--|--|--|--|---|--|--|--|---|--|
| BIRTH NO. 67 2273 | | M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) WILLIAM O. GRIEVES | | 2. DATE AND HOUR OF DEATH March 7, 1967 12:15 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 99 (DCA) Union Memorial Hospital | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 9.03 D. STREET ADDRESS (If rural, give location) 3620 Rexmere Road--18 | | | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | | 8. DATE OF BIRTH 11-18, 1902 | | 9. AGE (In years last birthday) 64 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Comm. Merchant-Whse. Produce | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME William T. Grievess | | | | 14. MOTHER'S MAIDEN NAME Evelyn A. Rider | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 220306942 | | 17. INFORMANT Martha J. Grievess | | ADDRESS same | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Occlusion (A) DUE TO ANTECEDENT CAUSES (B) DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | CAUSE OF DEATH Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 1 hour | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Mar 6 19 67 to Mar 7 19 67 , that (I) (we) last saw the deceased alive on Mar 7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE  Dr. Loy M. Zimmerman | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Mar. 7, 67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS 3202 Harford Rd., Baltimore, Md. | | | | | | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) burial | | 24B. DATE 3-10-67 | | 24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Leonard J. Buck, Inc.--Balto., Md.--14 | | ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|--|--|--|
| BIRTH NO. 67 2274 | | CITY OF BALTIMORE CERTIFICATE OF DEATH | | Registered No. 67 2274 | |
| 1. NAME OF DECEASED (Type or Print) Wesley T. Arnold | | | 2. DATE AND HOUR OF DEATH 4:00 PM 3/6/67 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND Church Home & Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore 35 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore XXXXXXXXXXXX | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore M. D. -27-06 | | |
| | | | D. STREET ADDRESS (If rural, give location) 6223 Fair Oaks Avenue | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7-14-06 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired mill worker | | 10B. KIND OF BUSINESS OR INDUSTRY Owens Yacht Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? American | | 13. FATHER'S NAME Marcellus Arnold | | | |
| 14. MOTHER'S MAIDEN NAME Martha Wotring | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 21-12-2111 | | 17. INFORMANT Mrs. Elsie E. Arnold ADDRESS (Same) | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 163 X I | | CAUSE OF DEATH (A) DUE TO CARCINOMA of the lungs with wide spread (B) DUE TO Metastasis - especially obstructive to the (C) Esophagus - inoperable | | INTERVAL BETWEEN ONSET AND DEATH 4 years | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. See ABC - C | | | |
| 19A. DATE OF OPERATION 2-14-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Respiratory Embarrassment | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-24-1967 to 3-6-1967 , that (I) (we) last saw the deceased alive on 3-6-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jan R. Anderson M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 3-6-67 | |
| 23C. PHYSICIAN'S NAME (Type) Jan R. Anderson M.D. | | | | 23D. ADDRESS Church Home & Hosp | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/9/67 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | | |
| 25B. NAME OF REGISTRAR Leonard J. Ruck, Inc. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. ADDRESS Baltimore, Md. 21214 | | | |



48-78-94 1B

P-40067 2275

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

67 2275

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

James W. Paul, Sr.

2. DATE AND HOUR OF DEATH

3/6/67

2¹⁰ A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224

31

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND, Balto. Co

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Essex

D. STREET ADDRESS (If rural, give location) Ave.

2005 HOLLY BEACH ROAD #21221

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

12-18-76

9. AGE (In years
last birthday)

90

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Marine Engineer Ret.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Paul

14. MOTHER'S MAIDEN NAME

Cora
ANNEX MEEKS15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
213-18-3229

17. INFORMANT

Kathryn Jacobsen
RECORDS-BCH-4940 EASTERN AVENUE

ADDRESS

21224

18. 331X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebral hemorrhage 2/28 to 3/6
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/28 1967 to 3/6 1967.
that (I) (we) last saw the deceased alive on 3/5 1967 and that in my (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Richard J. Owellen M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

3/6/67

23C. PHYSICIAN'S
NAME (Type)

DR. RICHARD J. OWELLEN

M.D.

23D. ADDRESS

BCH-4940 EASTERN AVENUE, BALTIMORE, MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3-9-67

24C. NAME OF CEMETERY or CREMATORY

Parkwood

24D. LOCATION

(City, town, or county)

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

MAR 7 1967

25B. NAME OF REGISTRAR

Leonard J. Ruck, Inc., 5305 Harford Rd.

25C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, Inc., 5305 Harford Rd.

FUNERAL DIRECTOR: IMPORTANT

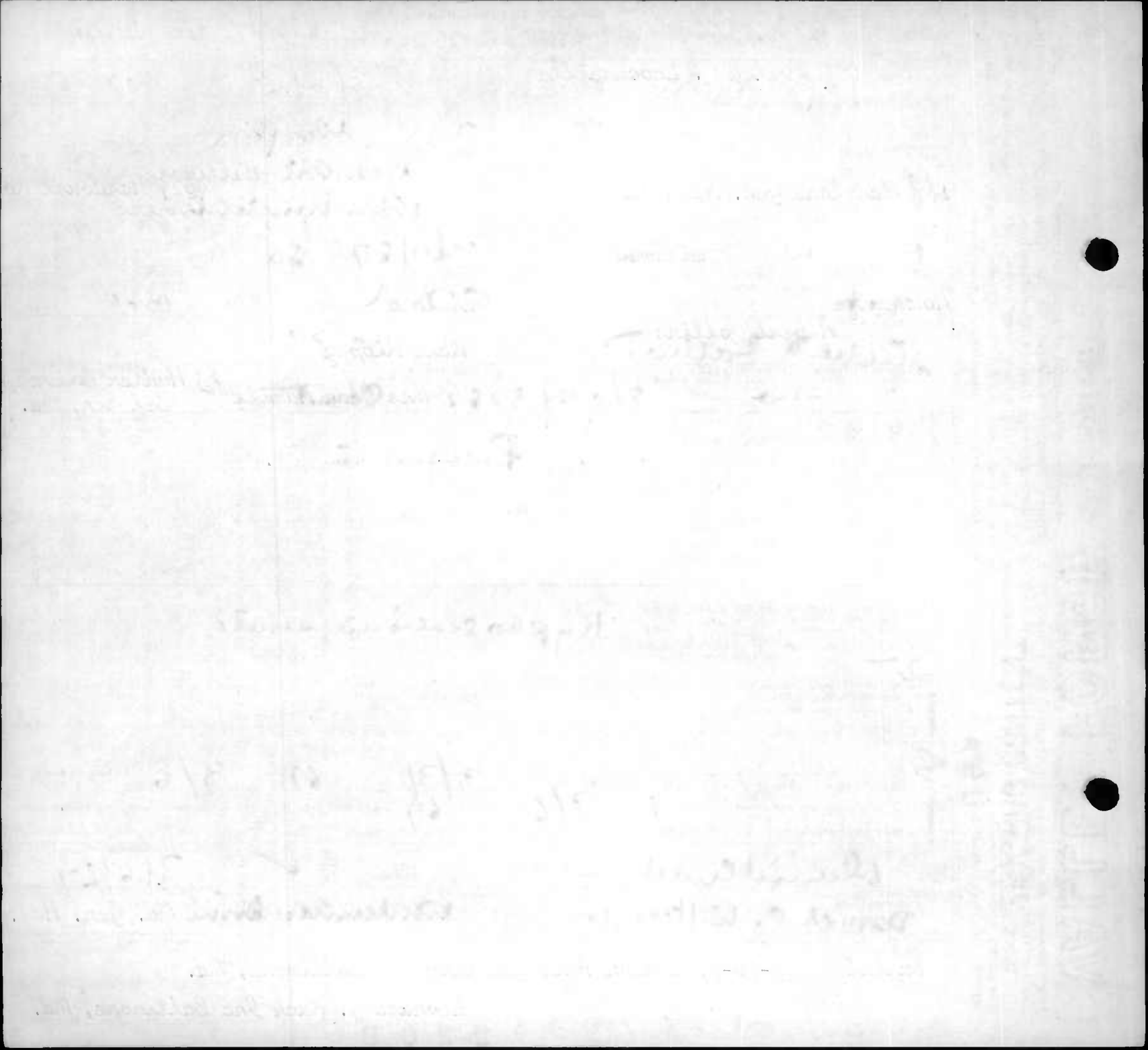
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

-01-

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------|---|--|---------------------------------|--|--|------------------------------|--|--|
| BIRTH NO. 67 2276 | | | | | CERTIFICATE OF DEATH | | | | |
| Registered No. 67 2276 | | | | | | | | | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Evelyn C. Lapourville</i> | | | | | 3/6/67 10:25 P. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | A. STATE B. COUNTY | | | | |
| 48 Maryland Gen. Hospital | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| | | | | | 4829 Harcourt Rd | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| F | W | widowed | 3/6/87 | 50 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Housewife | | | Maryland | | | USA | | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | | | | |
| Albert Collins | | | Kate Rippey | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| No | | | 220 44 5282 | | Mrs Jean Hamill | | | | |
| 18. 600.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | (A) DUE TO | | | | | | |
| | | | Pulmonary | | | | | | |
| | | | (B) DUE TO | | | | | | |
| | | | Atelectasis, pulmonary infarction | | | | | | |
| | | | (C) Uremia Pyelonephritis | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Kyphoscoliosis, senile | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | | | yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/31 1967 to 3/6 1967, that (I) (we) last saw the deceased alive on 3/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED | |
| Daniel C. Wilkerson | | | | | | | | 3/6/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | |
| Daniel C. Wilkerson | | | | | Md. Gen. Hos. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | | 24D. LOCATION (City, town, or county) (State) | |
| burial | | | 3-10-67 | | Loudon Park Cemetery | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR | | | 25C. FUNERAL DIRECTOR | | | |
| MAR 7 1967 | | | Robert E. Jackson | | | Leonard J. Ruck Inc Baltimore, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2277 | |
|---|--|--|--|--|--|
| BIRTH NO. 67 2277 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>Kennebeker Mr John</i> | | | | 2. DATE AND HOUR OF DEATH <i>3/5/67 10:15 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hospital</i> | | | | A. STATE <i>Maryland</i> B. COUNTY <i>Washington</i> | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Hagerstown 71-03</i> | |
| 5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | | | | D. STREET ADDRESS (If rural, give location) <i>2317 Marsh Pike</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i> | | | | 8. DATE OF BIRTH <i>3/31/1903</i> | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | 9. AGE (In years last birthday) <i>63</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>George Kennebeker</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Adelaide Harman</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Bon Secours Hospital Records</i> | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>420.04-154X</i> | | | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) <i>Pulmonary edema</i> | |
| ANTECEDENT CAUSES | | | | (B) <i>Arterioscl. heart disease</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <i>Carcinoma, rectum & recurrence</i> | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/20/67</i> 19 to 19, that (I) (we) last saw the deceased alive on <i>3/5/66</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>James R. Lee</i> | | | | 23B. DATE SIGNED <i>3-5-67</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | 24B. DATE <i>3/8/1967</i> | |
| 24C. NAME OF CEMETERY or CREMATORY <i>Rose Hill Cemetery</i> | | | | 24D. LOCATION (City, town, or county) (State) <i>Hagerstown, Md.</i> | |
| 25A. DATE REHEARSE HEALTH DEPT <i>1967</i> | | | | 25B. NAME OF REGISTRAR <i>Wm. E. Taylor</i> | |
| 25C. FUNERAL DIRECTOR <i>Wm. E. Taylor</i> | | | | ADDRESS <i>Baltimore, Md.</i> | |

2-7-65

Project 100

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MERTON

LEVI

WETZEL

~~WETZEL~~

2. DATE AND HOUR PRONOUNCED DEAD

March 3, 1967

10:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2137 Wilkins Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 4, 1907

9. AGE (In years
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Track foreman

10B. KIND OF BUSINESS OR INDUSTRY

Railroad Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Hans Wetzel

14. MOTHER'S MAIDEN NAME

Blanche (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Doris N. Wetzel 2139 Wilkins Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pneumonia
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic heart disease

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 3, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

March 6, 1967 Rest Haven

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Hansonville Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 7 1967

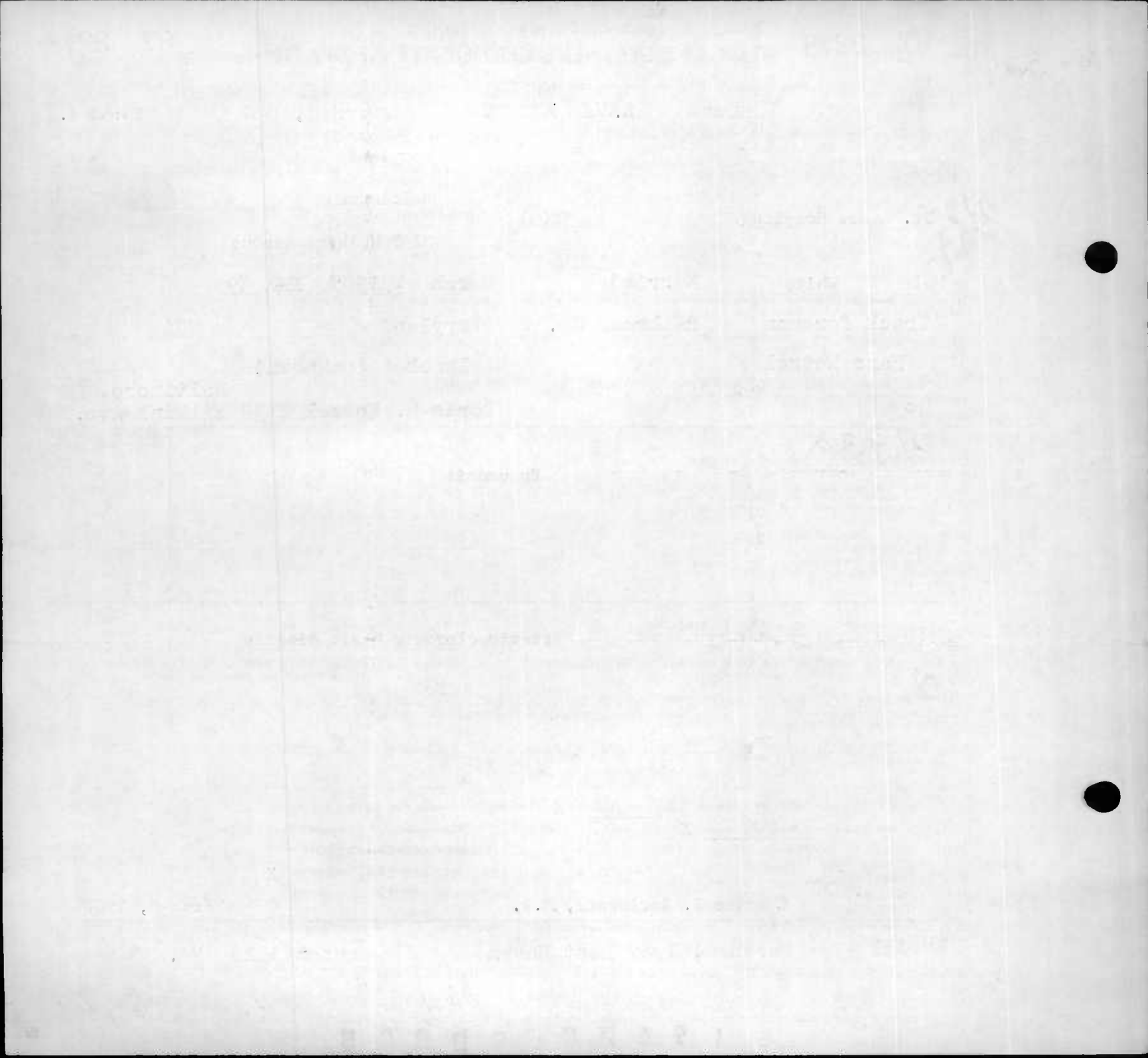
24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

DD Hutzler & Sons Union Bridge, Md

ADDRESS



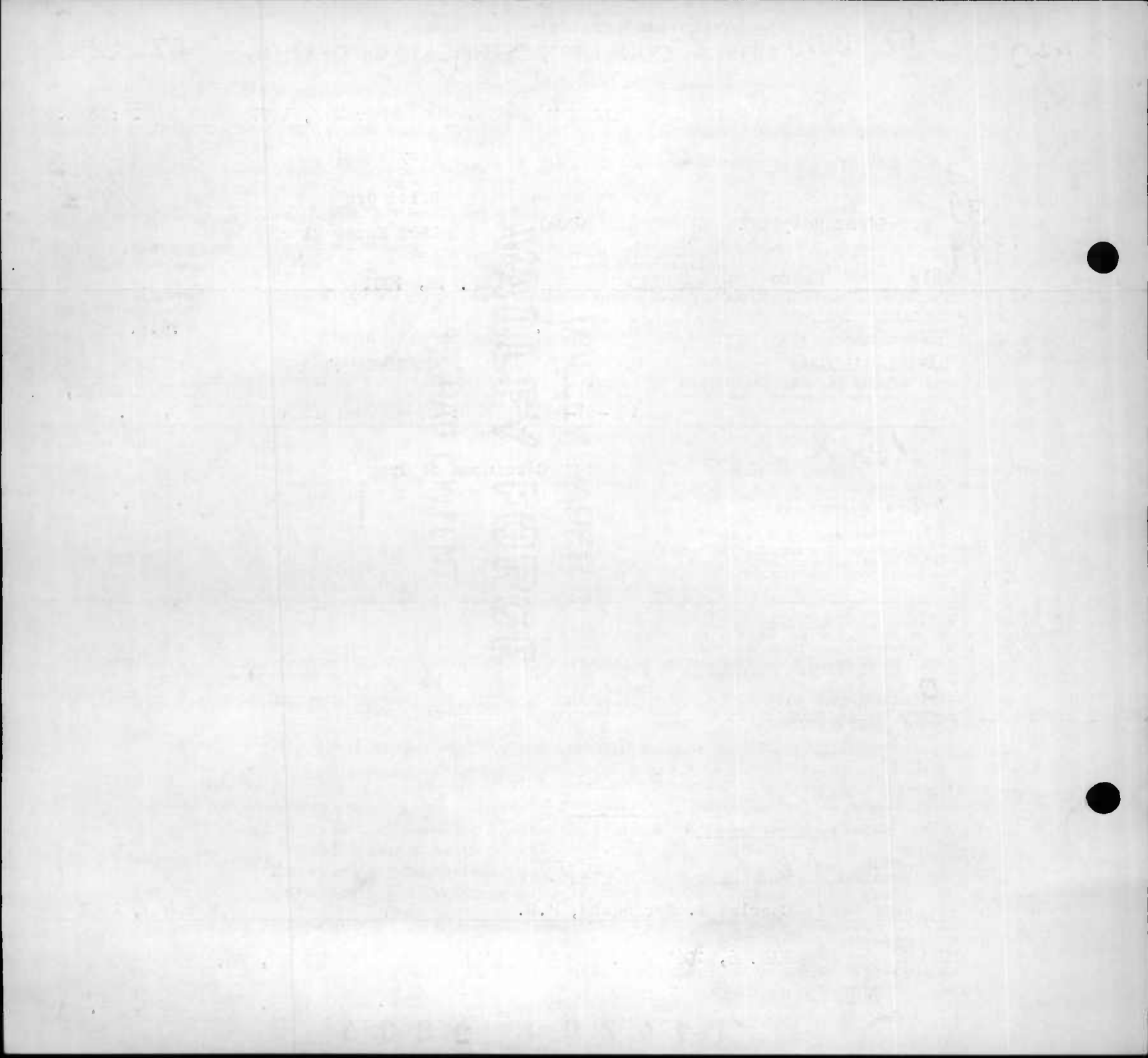
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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 2279 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2279

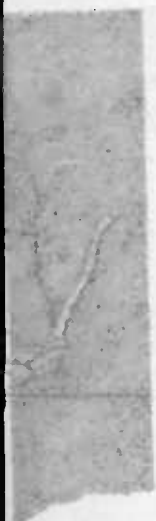
M.E. CASE NO.

| | | | |
|---|-------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) HARRY GALLOWAY | | 2. DATE AND HOUR PRONOUNCED DEAD March 3, 1967 10:10 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital (DOA) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1803 Eutaw Place | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH NOV. 16, 1901 |
| 9. AGE (In years last birthday) 65 | | 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINER | | 10B. KIND OF BUSINESS OR INDUSTRY FROSTBURG FUEL CO. | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME DANIEL GALLOWAY | | 14. MOTHER'S MAIDEN NAME COUSUELO FISHER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 182-01-6393A | |
| 17. INFORMANT MRS. SUSAN RANDOLPH, FROSTBURG, MD. | | 18. ADDRESS 98 CHESTNUT STREET, | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 3, 1967 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23B. DATE MAR. 6, 1967 | |
| 23C. NAME OF CEMETERY or CREMATORY FBG. MEMORIAL PARK | | 23D. LOCATION (City, town, or county) (State) FROSTBURG, MD. | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 7 1967 | | 24B. NAME OF REGISTRAR Robert E. Farber | |
| 24C. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. | | 24D. ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

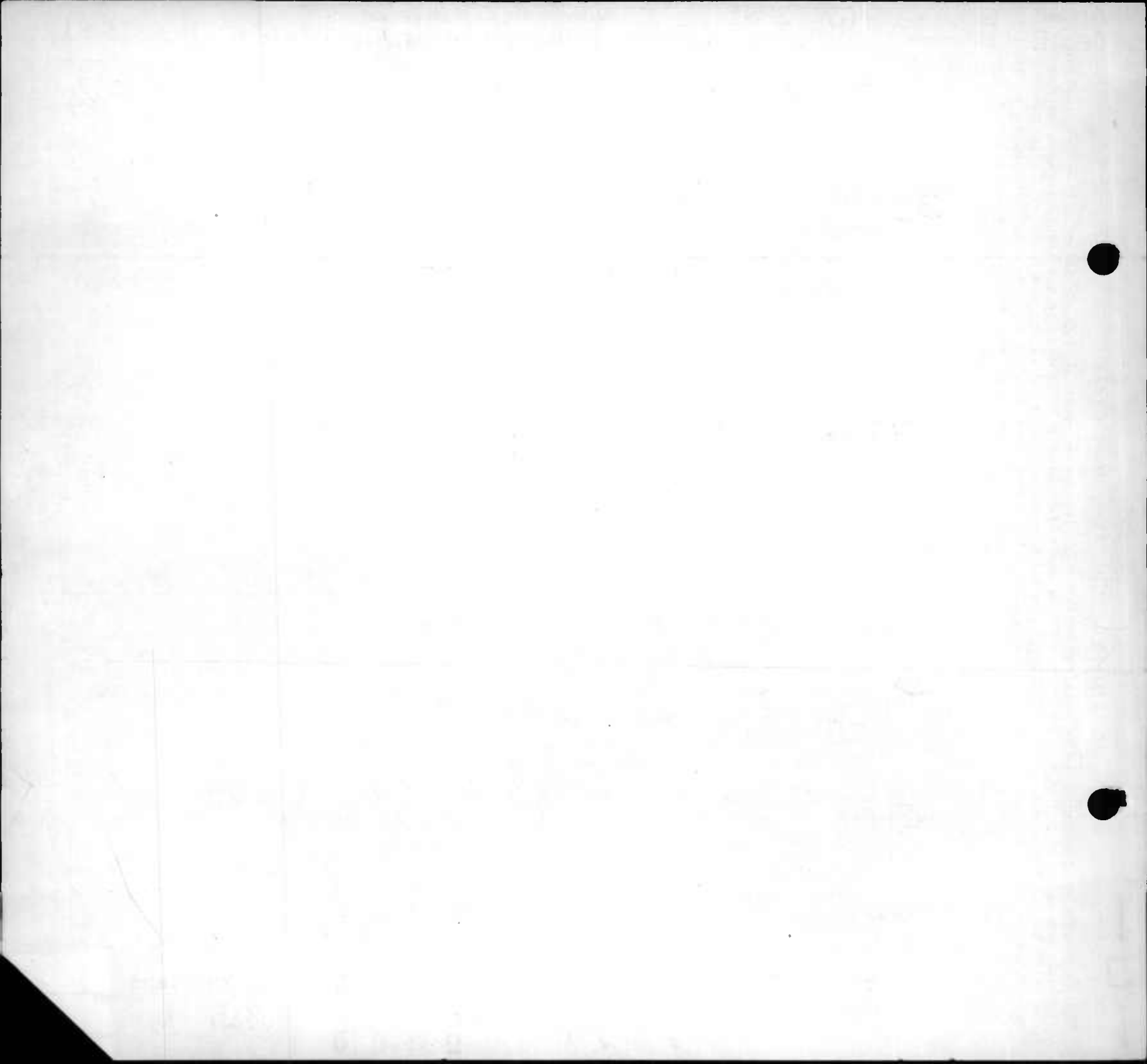
| | | | | | |
|---|---------------------|--|------------------------------------|--|---|
| BIRTH NO. 67 2280 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2280 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Watson, John B. (John S.)</i> | | 2. DATE AND HOUR OF DEATH <i>3-4-67 - 2:05 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> 8. COUNTY <i>Baltimore</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>North Charles General Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>2834 W. Mulberry</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>3-12-99</i> | 9. AGE (In years last birthday) <i>67</i> | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>B & O Railroad</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>W. V. Watson</i> | | 14. MOTHER'S MAIDEN NAME <i>Mary Rawlings</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WWII</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>James E. Watson, Huntingtown, Maryland</i> | |
| 18. <i>260X-180X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>acute urinary retention</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Diabetes mellitus</i> | | (B) <i>Diabetes mellitus</i> | | (C) <i>uremia and septicaemia</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Recurrent hypernephroma, right</i> | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2-12-67</i> 19 to <i>3-4</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3-4-67</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>J. S. Morozati</i> | | | | 23B. DATE SIGNED <i>3-4-67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Sylvan Goodman</i> | | | | 23D. ADDRESS <i>Prince Frederick Calvert Md.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>Mar. 7, 1967</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Wesley Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Prince Frederick Calvert Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 7 1967</i> | | | |
| 25B. NAME OF REGISTRAR <i>John E. Faguna</i> | | 25C. FUNERAL DIRECTOR <i>Hutchins Funeral Home Owings, Md.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------|---|---|---|---|
| 67-06256 67 2281 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2281 | |
| BIRTH NO. 67-06256 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. 67-06256 | | 1. NAME OF DECEASED (Type or Print) BABY REED | | 2. DATE AND HOUR OF DEATH 9:40 p.m. 3/6/67 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| 33 JOHNS HOPKINS HOSPITAL | | B. COUNTY | | BALTIMORE, 12 | |
| | | D. STREET ADDRESS (If rural, give location) | | 2211 AISMITH ST. 9-08 | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) INFANT | 8. DATE OF BIRTH 3-6-67 | 9. AGE (In years, last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME LUCINDA REED | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 2140 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 0446 ANTECEDENT CAUSES 1694 DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Prematurity (B) _____ (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 16 56/60 hrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 0446 3/6 67 to 2140 3/6 67 , that (1) (we) last saw the deceased alive on 3/6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 23A. SIGNATURE Dr. Elliott | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/6/67 | |
| 23C. PHYSICIAN'S NAME (Type) DR. ELLIOTT | | 23D. ADDRESS Johns Hopkins Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 3/7/67 | | 24C. NAME OF CEMETERY or CREMATORY The Johns Hopkins Hosp. Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1967 | | 25B. NAME OF REGISTRAR Q. A. E. [Signature] | | 25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2282 | |
|--|---------------------|--|--|--|---|
| BIRTH NO. 67 2282 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WHITE, WILLIAM ABRAHAM | | 2. DATE AND HOUR OF DEATH 3-6-1967 11:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GENERAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3900 HILTON Rd. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 1-27-1891 | 9. AGE (In years last birthday) 76 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) RUSSIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME HARRY WHITE | | 14. MOTHER'S MAIDEN NAME KAPLAN, TOBY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. 214-24-3801A | 17. INFORMANT NORTH CHARLES GEN. HOSP. CHART | | ADDRESS |
| 18. 203X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) MULTIPLE MYELOMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A.S.C.V.D. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-14-1966 to 3-6-1967 , that (I) (we) last saw the deceased alive on 3-6-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Juan F. Olean | | | | 23B. DATE SIGNED 3-6-1967 | |
| 23C. PHYSICIAN'S NAME (Type) SAMUEL HANKIN | | 23D. ADDRESS 1010 ST. PAUL Street, BALTIMORE, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/8/1967 | | 24C. NAME of CEMETERY or CREMATORY BETH TFILOH | |
| 24D. LOCATION BALTO. | | (City, town, or county) (State) MD | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR SYLOANS LEWIS & SON, INC. - GARRISON, MD | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2283</u> | |
|--|----------------------------|---|------------------------------------|---|--|
| BIRTH NO. <u>67 2283</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>BOCK PHILLIP.</u> | | 2. DATE AND HOUR OF DEATH <u>9-30 A.M. MARCH 5th 1967</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u> <u>42 BALTIMORE</u> | | A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>5605 WOODCREST AVE</u> | | | |
| 5. SEX <u>MALE.</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED.</u> | 8. DATE OF BIRTH <u>3-17-72</u> | 9. AGE (In years last birthday) <u>94 years</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Steel Business</u> | | 11. BIRTHPLACE (State or foreign country) <u>Penna.</u> | |
| 13. FATHER'S NAME <u>John Bock</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Hammond Reed</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>195-07-3776 A</u> | | 17. INFORMANT ADDRESS <u>Mrs. Mary Jane Bock-5605 Woodcrest Ave. 21215</u> | |
| 18. <u>34101</u> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Bleeding duodenal ulcer.</u> | | (A) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2-20-67</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bleeding duodenal ulcer.</u> | | 20A. AUTOPSY? (Yes or No) <u>YES.</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-19-1967</u> 19 to <u>3-5-1967</u> 19, that (I) (we) last saw the deceased alive on <u>5th MARCH</u> 19 <u>67</u> at <u>9-15 A.M.</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>K. T. Sabura</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED |
| 23C. PHYSICIAN'S NAME (Type) <u>K. T. Sabura</u> | | 23D. ADDRESS M.D. <u>Sinai Hospital Balt., Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>3/9/67</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olivet</u> | | 24D. LOCATION (City, town, or county) (State) <u>New Cumberland, Pa.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1967</u> | | 25B. NAME OF REGISTRAR <u>Loring Byers</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>8728 Liberty Rd. Randallst</u> | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--|---|--|--|--|
| BIRTH NO. 67 2284 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH MARCH 6, 1967 2:15 A.M. | | | |
| 1. NAME OF DECEASED (Type or Print) MARY E. VOLK | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO. 29, MD. | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Carroll Co. | | 5. SEX FEMALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) SYKESVILLE | | 8. DATE OF BIRTH 10-19-94 | | 9. AGE (In years last birthday) 72 | |
| D. STREET ADDRESS (If rural, give location) RFD1, BOX 29 | | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME UNKNOWN | |
| 14. MOTHER'S MAIDEN NAME UNKNOWN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 217-20-8934 | |
| 17. INFORMANT ST. AGNES HOSPITAL, WILKENS & CATON AVE. | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death) Arteriosclerotic heart disease Actual fibrillation due to Coronary heart failure | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Fractured left hip complicated by staphylococcal infection | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, which rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Shake to death | | | |
| 19A. DATE OF OPERATION 2/16/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) R.F.D. #1 Sykesville, Md. | |
| 21D. TIME OF INJURY (APPROX.) Feb. 9, 1967? | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fell out of bed | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 9 1967 to MARCH 6 1967 , that (I) (we) last saw the deceased alive on MARCH 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>A. Borromeo</i> | | | | 23B. DATE SIGNED 3/6/67 | |
| 23C. PHYSICIAN'S NAME (Type) A. BORROMEIO | | | | 23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/9/67 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park | |
| 24D. LOCATION Harford Rd. Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1967 | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallst | | | |

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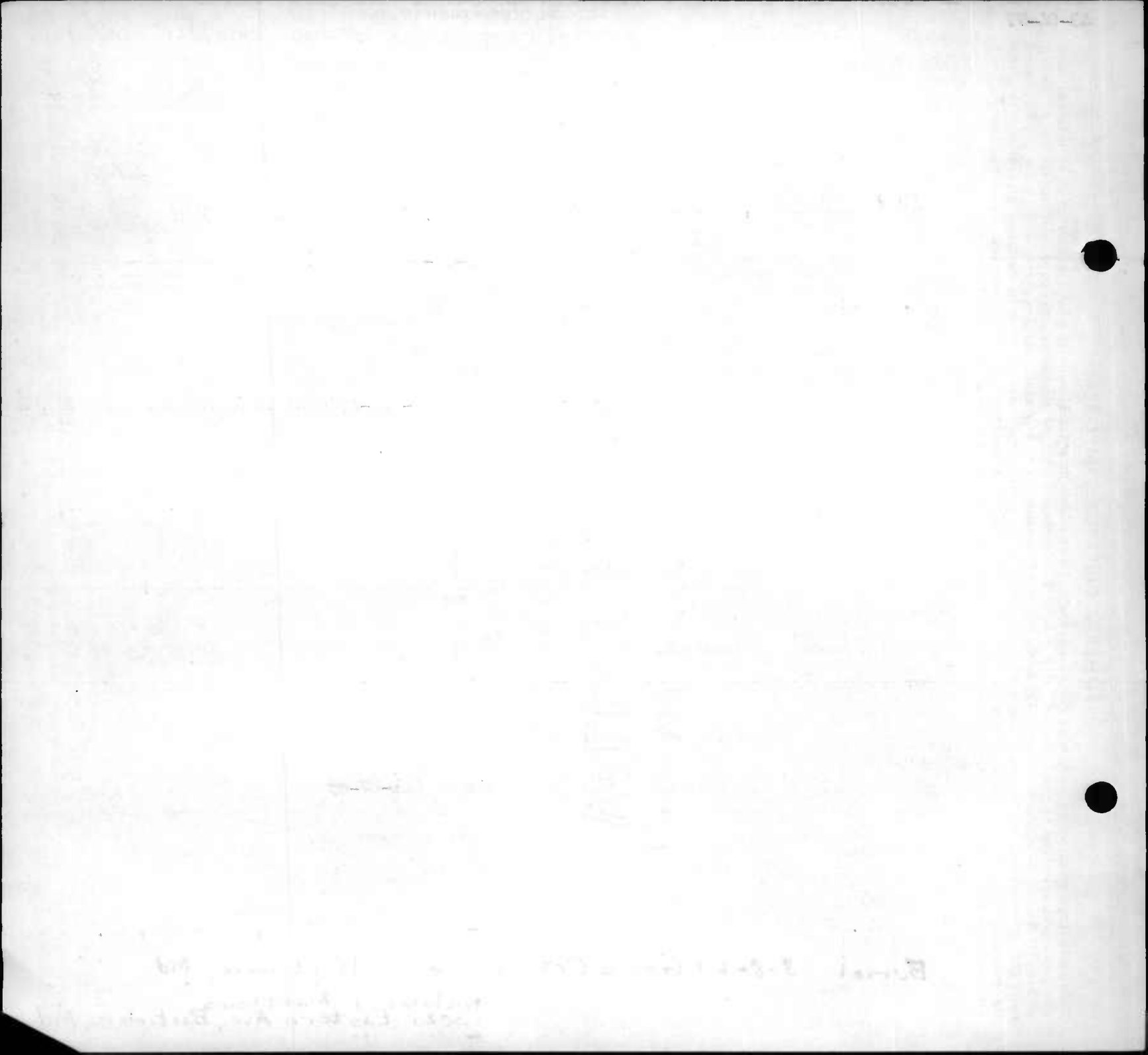
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2285

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-------------------------|--|-------------------------------------|
| BIRTH NO. 67 2285 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) <i>Barras, NICHOLAS</i> | | 2. DATE AND HOUR OF DEATH <i>3/5/67 1:45 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224</i> | | A. STATE <i>MARYLAND</i> B. COUNTY | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> | | D. STREET ADDRESS (If rural, give location) <i>513 S. OLDHAM STREET #21224</i> | |
| 5. SEX <i>MALE</i> | 6. RACE <i>WHITE</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>SEPARATED</i> | 8. DATE OF BIRTH <i>11-30-89</i> |
| 9. AGE (In years last birthday) <i>77</i> | | 10. AGE (In years last birthday) <i>77</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mgr.-Coffee House</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>GREECE</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>ALEX</i> | | 14. MOTHER'S MAIDEN NAME <i>ASMINOS</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>220-24-5356</i> | |
| 17. INFORMANT <i>RECORDS-BCH-4940 EASTERN AVENUE, BALTIMORE, MD</i> | | ADDRESS | |
| 18. <i>465 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Pulmonary Embolus</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Asthma</i> | | <i>30 years</i> | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>11-27-65</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>3/2</i> 19 <i>67</i> and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Judith Hall</i> | | 23B. DATE SIGNED <i>3/5/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>DR. JUDITH HALL</i> | | 23D. ADDRESS <i>#21224 BCH-4940 EASTERN AVENUE, BALTIMORE, MD.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3-8-67</i> | |
| 24C. NAME OF CEMETERY or CREMATORY <i>Greek Orthodox Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 8 1967</i> | | 25B. NAME OF REGISTRAR <i>R. B. E. Taylor</i> | |
| 25C. FUNERAL DIRECTOR <i>Nicholas T. Matthews</i> | | ADDRESS <i>3021 Eastern Ave., Baltimore, M</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2286 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2286 | |
|---|-------------------------|--|-----------------------------------|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Henry W. Fuller</i> | | | | 2. DATE AND HOUR OF DEATH <i>3/7/67 120 PM</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secour Hospital</i> | | (If not in hospital or institution, give street address or location) | | A. STATE <i>Maryland</i> | | B. COUNTY <i>Anne Arundel Co.</i> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Pasadena 52-00</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>1 Brookfield Rd.</i> | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>6-6-15</i> | | 9. AGE (In years last birthday) <i>51</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Gas & Electric Co</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Wm H Fuller</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Anna Fick</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>213-10-5357</i> | | 17. INFORMANT <i>CATHERINE FULLER</i> | | ADDRESS <i>1 Brookfield Rd.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>ASHD</i> | | | | CAUSE OF DEATH (A) DUE TO <i>Acute myocardial infarction</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>yes days</i> | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | (B) DUE TO | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>March 6, 1967</i> to <i>March 7, 1967</i> , that (I) (we) last saw the deceased alive on <i>March 7, 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Argon Jitar</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>3/7/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS <i>Bon Secour Hosp. Balto, Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>3-10-67</i> | | 24C. NAME of CEMETERY or CREMATORY <i>MEADOWRIDGE MEMORIAL</i> | | 24D. LOCATION (City, town, or county) (State) <i>Howard Cty. Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 8 1967</i> | | 25B. NAME OF REGISTRAR <i>John E. Johnson</i> | | 25C. FUNERAL DIRECTOR <i>Geo L. Schwab FUNERAL HOME</i> <i>Francis Miller 2101 Frederick Ave</i> | | | |

Don J. Scott Hospital

Mrs. White Morris

2nd Division
Post Office Co

Wm H. Fuller

1 Brookfield Rd

C. C. 12 21

Marland

Anna Fick

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------|---|--|--|--|---|--|-------------------------------------|--|
| BIRTH NO. 67 2287 | | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2287 | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Jerry Jaiurus GERALD W. JONES Sr. | | | | | 2. DATE AND HOUR PRONOUNCED DEAD 3-6-67 9:25 P. M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3-13-67 CHURCH HOME & HOSPITAL - DOA | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-13 D. STREET ADDRESS (If rural, give location) 2802 Waldorf Avenue 21215 | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 9-24-1893 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Engineer | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Willard Jones | | | | | 14. MOTHER'S MAIDEN NAME Elizabeth - Unknown | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes | | | | 16. SOCIAL SECURITY NO. 542-07-7159 | | 17. INFORMANT ADDRESS Mamie May Jones -2802 Waldorf Avenue | | | |
| 18. CAUSE OF DEATH | | | | | | | | | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic and hypertensive cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. DATE SIGNED 3-7-67 | | | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 3-10-1967 | | 23C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery Baltimore National Cem. | | | 23D. LOCATION (City, town, or county) (State) Baltimore Maryland | | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 8 1967 | | | 24B. NAME OF REGISTRAR R. E. Farber | | | 24C. FUNERAL DIRECTOR ADDRESS Ellsworth Armacost Ellsworth Armacost-4600 Liberty Hgts | | | |

V.S. 153

3-13-67

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2288</u> | |
|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | |
| IRTH NO. <u>67 2288</u> M.E. CASE NO. <u>67-04773</u> | | 1. NAME OF DECEASED (Type or Print) DROWSKY, BABY GIRL | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>40</u> ST. AGNES HOSPITAL (If not in hospital or institution, give street address or location) WILKENS & CATON AVES. BALTO., MD. 21229 | | 2. DATE AND HOUR OF DEATH MARCH 5, 1967 10:35AM. | | | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 3-5-67 | |
| 13. FATHER'S NAME ALBERT DROWSKY | | 14. MOTHER'S MAIDEN NAME MELVA (HOGAN) | | 9. AGE (In years last birthday) 1 41 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 11. BIRTHPLACE (State or foreign country) BALTO. MD. | |
| 17. INFORMANT ST. AGNES RECORDS - BALTO., MD. 21229 | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PREMATURITY INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from MARCH 5, 1967 to MARCH 5, 1967, that (X) (we) lost saw the deceased alive on MARCH 5, 1967 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death. | | | | | |
| 23A. SIGNATURE <i>R. O. Guzman</i> | | | | 23B. DATE SIGNED 3 6 67 | |
| 23C. PHYSICIAN'S NAME (Type) REYNALDO GUZMAN | | | | 23D. ADDRESS ST. AGNES HOSPITAL-BALTO., MD. 21229 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-7-1967 | | 24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Ritchie Hgwy., A.A.Co., Maryland | | 25A. DATE RECEIVED BY HEALTH DEPT. MAR 8 1967 | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Talbott</i> | | 25C. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hgwy., Baltimore | | | |

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North Hill Nursery, N.Y.

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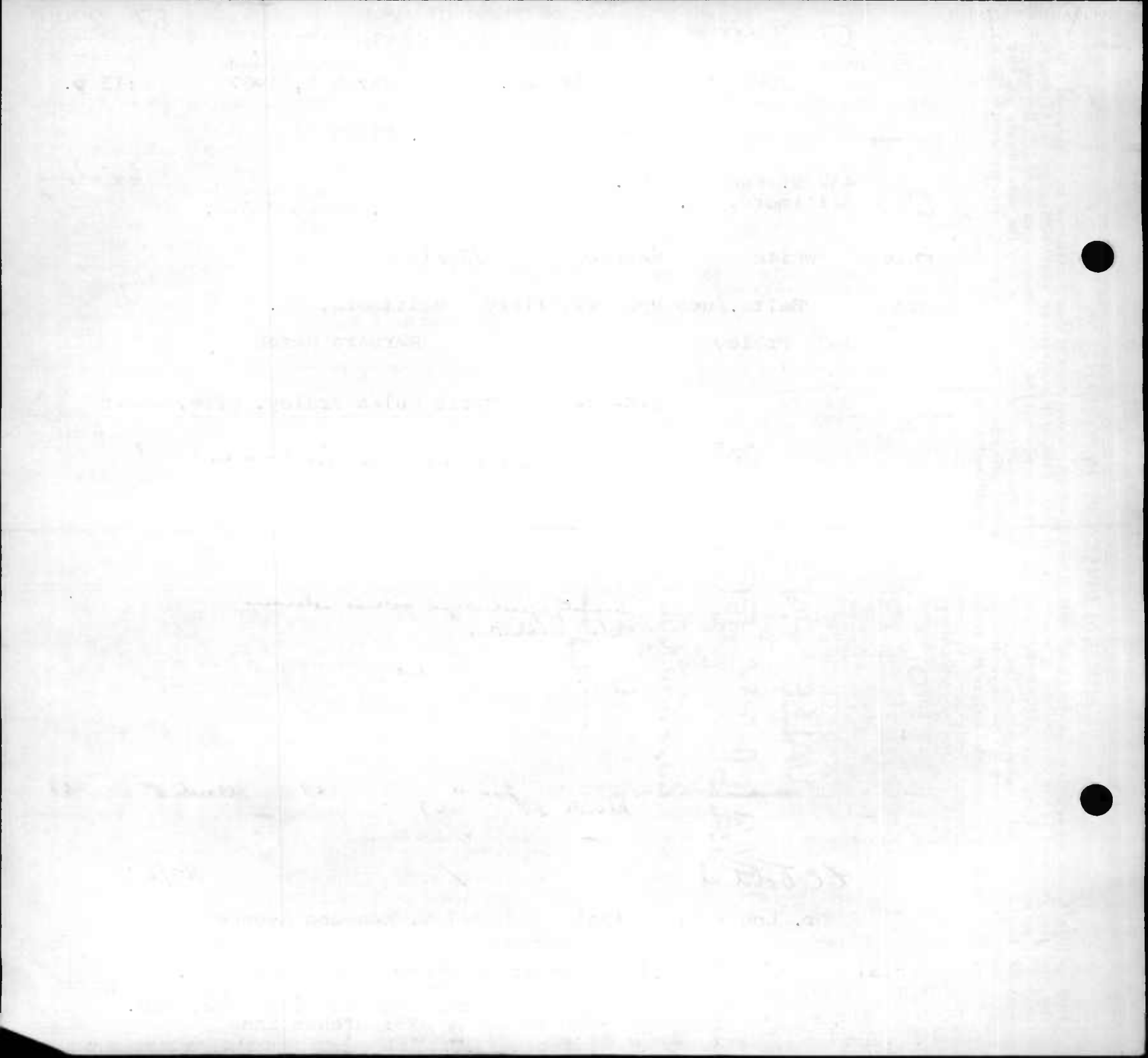
For details see 1912/13

7

Annual Report 1912/13

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| P-640 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2290 | |
|--|-------------------------|---|--------------------------------------|---|---|
| BIRTH NO. 67 2290 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JOHN JOSEPH PRALEY, JR. | | 2. DATE AND HOUR OF DEATH March 5, 1967 6:15 p. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 21224 B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 432 N. Kenwood Ave. Baltimore, Md. 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | 6-02 | |
| | | D. STREET ADDRESS (If rural, give location) 432 N. Kenwood Ave. | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 9/28/1883 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard | | 10B. KIND OF BUSINESS OR INDUSTRY Pure Rye Distillery | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME John Praley | | 14. MOTHER'S MAIDEN NAME Barbara Rezek | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-05-7619 | | 17. INFORMANT ADDRESS Marie Hulka Praley, wife, above | |
| 18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>cardio-renal-vascular disease</i> DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH ? | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>arteriosclerosis, generalized arteriosclerosis, chronic nephritis</i> | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 11</i> 1967 to <i>March 5</i> 1967, that (I) (we) last saw the deceased alive on <i>March 5</i> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>L. C. Dobihal</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>3/7/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Louis C. Dobihal | | 23D. ADDRESS M.D. 447 N. Kenwood Avenue | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/9/67 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1967 | | 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3331 Brehms Lane | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2291 | |
|--|---------------|--|---------------------------|--|---|
| BIRTH NO. 67 2291 | | CERTIFICATE OF DEATH | | Registered No. 67 2291 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CAROLINE J. SEVICK or SEVCIK | | 2. DATE AND HOUR OF DEATH March 5, 1967 7 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Md. 21205 | | Baltimore | |
| 824 N. Streeper St., Baltimore, Md., 21205 | | D. STREET ADDRESS (If rural, give location) | | 824 N. Streeper St. | |
| 6. SEX female | 7. RACE white | 8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 9. DATE OF BIRTH 12/29/95 | 10. AGE (In years last birthday) 71 | 11. If Under 1 Yr. Months: Days: 11 Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Operator | | 10B. KIND OF BUSINESS OR INDUSTRY Continental Can Co. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Roth | | 14. MOTHER'S MAIDEN NAME Anna Vsetecka | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. 220-22-5135 | | 17. INFORMANT 5202 Benson Ave. 21227 Margaret A. Shryock, dght. | | 18. CAUSE OF DEATH | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) Coronary Thrombosis | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| ANTECEDENT CAUSES | | (B) cerebral Vascular disease | | 1960 | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Hypertension | | ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Peripheral Vascular disease | | ? | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10/29 1966 to March 5 1967, that (I) (we) last saw the deceased alive on 11/16 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Louis Klimes M.D. | | | | 23B. DATE SIGNED March 7, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Louis Klimes M.D. | | | | 23D. ADDRESS 4814 Bowleys Lane | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/9/67 | | 24C. NAME OF CEMETERY or CREMATORY Bohemian National Cem. | |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| 24G. DATE REC'D BY HEALTH DEPT. MAR 8 1967 | | 24H. NAME OF REGISTRAR Robert E. Finkbeiner | | 24I. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601 E. Madison St. | |

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

BIRTH NO. 67 2292 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2292

M.E. CASE NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| REGINA BYRNS | | | | 3-6-67 12:35 AM. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>42</u> SINAI HOSPITAL - DOA <u>99</u> | | | | A. STATE Mayrland B. COUNTY Baltimore <u>01</u> | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Reisterstown <u>53-00</u> | | | |
| 5. SEX Female | | | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 6-29-1961 6-29-1961 | | 9. AGE (In years last birthday) 5 | |
| 11. BIRTHPLACE (State or foreign country) Olney, Md | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME Thomas Byrns | | | | 14. MOTHER'S MAIDEN NAME Margaret Livesey | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Thomas Byrns Jr. Reisterstown, Md | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic Wilm's tumor | | | | (A) DUE TO | | | |
| II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Werner U. Spitz, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) | | | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 23B. DATE 3-9-1967 | | 23C. NAME OF CEMETERY OR CREMATORY St. Johns | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 8 1967 | | | | 24B. NAME OF REGISTRAR F.C. Higinbotham | | 24C. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md | |
| 24D. ADDRESS | | | | 24E. ADDRESS | | | |

RECEIVED
 MAY 15 1961
 U.S. DEPARTMENT OF AGRICULTURE
 OFFICE OF THE SECRETARY

[Handwritten signature]

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1961 MAY 15

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2293 | |
|---|---------------|---|--------------------------------|--|--|
| BIRTH NO. 67 2293 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WILLA A. GRIFFIN | | | |
| 2. DATE AND HOUR OF DEATH | | MAR. 5, 67 6:50 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY Maryland 21236 Balto. Co. | | | |
| MONTEBELLO STATE HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00 | | | |
| 91 | | D. STREET ADDRESS (If rural, give location) 4000 Taylor Avenue | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH June 28, 1913 | 9. AGE (In years last birthday) 53 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY -- | | 11. BIRTHPLACE (State or foreign country) Penna. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME William H. Compton | | 14. MOTHER'S MAIDEN NAME Maybelle W. Hitchin | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No ---- | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Paul M. Griffin (Husband) Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) CARCINOMA OF LUNG. (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 30 mos. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO. | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (if) (this hospital) attended the deceased from 8-15 19 66 to 3-5 19 67, that (if) (we) last saw the deceased alive on 3-5 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (if) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Irving L. Cooperstein | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED MAR. 5, 67. | |
| 23C. PHYSICIAN'S NAME (Type or Print) Irving L. Cooperstein | | 23D. ADDRESS M.D. MONTEBELLO STATE HOSPITAL BALTO.-MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/8/1967 | | 24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1967 | | 25B. NAME OF REGISTRAR Eugene E. Seitz | |
| 25C. FUNERAL DIRECTOR ADDRESS Eugenia K. Seitz 5209 York Rd. Seitz Funeral Home Balto. Md. 2 1212 | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|-------------------------|---|--|---|---|---|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>67 2294</u> | | | | | |
| BIRTH NO. <u>67 2294</u> | | M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) <u>Agnes V. Steward</u> | | | 2. DATE AND HOUR OF DEATH <u>Mar 2, 67</u> <u>9.42 A.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Kent Co</u> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>UNIV. OF Md. Hosp.</u> <u>38</u> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>CHESTER TOWN</u> <u>64-37</u> | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>211 CROSS ST.</u> | | | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>SINGLE</u> | | 8. DATE OF BIRTH <u>10-8-22</u> | 9. AGE (In years last birthday) <u>44</u> | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>CHESTER TOWN, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | |
| 13. FATHER'S NAME <u>Wilbur Steward</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Katie Sheppard</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>-</u> | | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT <u>ROBINSON, JOHN</u> | | | ADDRESS <u>SAKE</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>754.3 I</u> <u>CONGENITAL HEART DIS.</u> <u>CONGESTIVE HEART FAILURE</u> | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> |
| | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2-28-67</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Severe Cong. Heart Failure</u> | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-11-67</u> 19 <u>67</u> to <u>3-2</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-2-67</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <u>E. S. Mondak</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>3-2-67</u> | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/6/1967</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Rich Neck Hall, Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Near Church Hill, Md.</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1967</u> | | | 25B. NAME OF REGISTRAR <u>Robert S. Jenkins</u> | | 25C. FUNERAL DIRECTOR <u>Kenneth W. W. W.</u> | | | ADDRESS <u>Chestertown, Md</u> | | |

John Smith

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2295</u> | |
|---|---------------------|---|-----------------------------------|---|---|
| BIRTH NO. <u>67 2295</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Schonebaum, Anna D.</u> | | 2. DATE AND HOUR OF DEATH <u>3/5/67</u> <u>1130 P.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | 27-26 | |
| | | D. STREET ADDRESS (If rural, give location) <u>6822 WILLIAMSON AVE. #15</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED-NEVER MARRIED <u>WIDOWED</u> DIVORCED (specify) | 8. DATE OF BIRTH <u>1/1/19</u> | 9. AGE (In years lost birthday) <u>88</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>POLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Abraham Gerstein</u> | | 14. MOTHER'S MAIDEN NAME <u>Zisel ?</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-54-1674</u> | | 17. INFORMANT <u>Mrs. Ida Haxman</u> ADDRESS <u>6822 Williamson Ave.</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>422.11</u> | | CAUSE OF DEATH (A) <u>CARDIORESPIRATORY FAILURE</u> DUE TO (B) <u>ASCVD</u> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>STRANGULATED FEMORAL HERNIA</u> | | | | | |
| 19A. DATE OF OPERATION <u>2/17/67</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>STRANGULATED HERNIA</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/17/1957</u> to <u>3/5/1967</u> , that (I) (we) last saw the deceased alive on <u>3/5/1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Hyman Greenfield</u> | | | | 23B. DATE SIGNED <u>3/5/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>HYMAN GREENFIELD</u> | | | | 23D. ADDRESS <u>SINAI HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/6/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Rodhe Zedek</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Feldman</u> | |
| 25C. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u> | | | | | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE A. LUCKE III

2. DATE AND HOUR PRONOUNCED DEAD

March 4, 1967 3:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)42
99 St. Agnes Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)
A. STATE B. COUNTY

Maryland

A-A-3

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Severna Park

D. STREET ADDRESS (If rural, give location)

100 Old County Road

52-00

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

NEVER MARRIED

8. DATE OF BIRTH

3-19-48

9. AGE (In years
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

WAREHOUSE

10B. KIND OF BUSINESS OR INDUSTRY

WESTINGHOUSE

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

George Albert Lucke Jr.

14. MOTHER'S MAIDEN NAME

Betty Lacey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Robert Lucke - Severna Park Md.

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.CAUSE OF DEATH
Laceration of heart and pericardium
with left hemothoraxINTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

(Partial)

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

highway

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
Baltimore Beltway 348 feet
south of Westland Boulevard overpass21D. TIME
OF INJURY
(APPROX.)

3-4-67

2:38

A

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

Partial

21F. HOW DID INJURY OCCUR?

Driver of auto which ran off road

53-00

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 4, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/8/67

23C. NAME OF CEMETERY OR CREMATORY

Glen Haven

23D. LOCATION

Glen Burnie Md

24A. DATE REC'D BY HEALTH DEPT.

MAR 8 1967

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Robert S. Baranec, Severna Park Md

ADDRESS

Page 11

24-11-2

Location of water in
with 100 ft. diameter

100 ft.

100 ft.

100 ft.

100 ft. diameter

100 ft. diameter

BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

AGNES ROGAN

SESSAMEN

2. DATE AND HOUR PRONOUNCED DEAD

3-5-67

4:30 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 26-05
6524 Fait Avenue 21224

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

DIVORCED

8. DATE OF BIRTH

JAN. 6, 1909

9. AGE (In years, ^{lost birthday} ~~11~~ 58 Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

OFFICE STAFF

10B. KIND OF BUSINESS OR INDUSTRY

TELEPHONE MFG.

11. BIRTHPLACE (State or foreign country)

IRELAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

PATRICK ROGAN

14. MOTHER'S MAIDEN NAME

HELEN O'BRIEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

213/03/9581

17. INFORMANT

HELEN T. ROGAN

309 CATHEDRAL ST.
BALTO. MD. 21201

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(A) Carbon monoxide poisoning - associated
with smoke and soot inhalation -
incidental to conflagration

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

House

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

6524 Fait Avenue 26-05

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3 5 '67 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Burned in house fire

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

3-6-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

3/8/67

23C. NAME of CEMETERY or CREMATORY

CATHEDRAL

23D. LOCATION

(City, town, or county)

BALTO. MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 8 1967

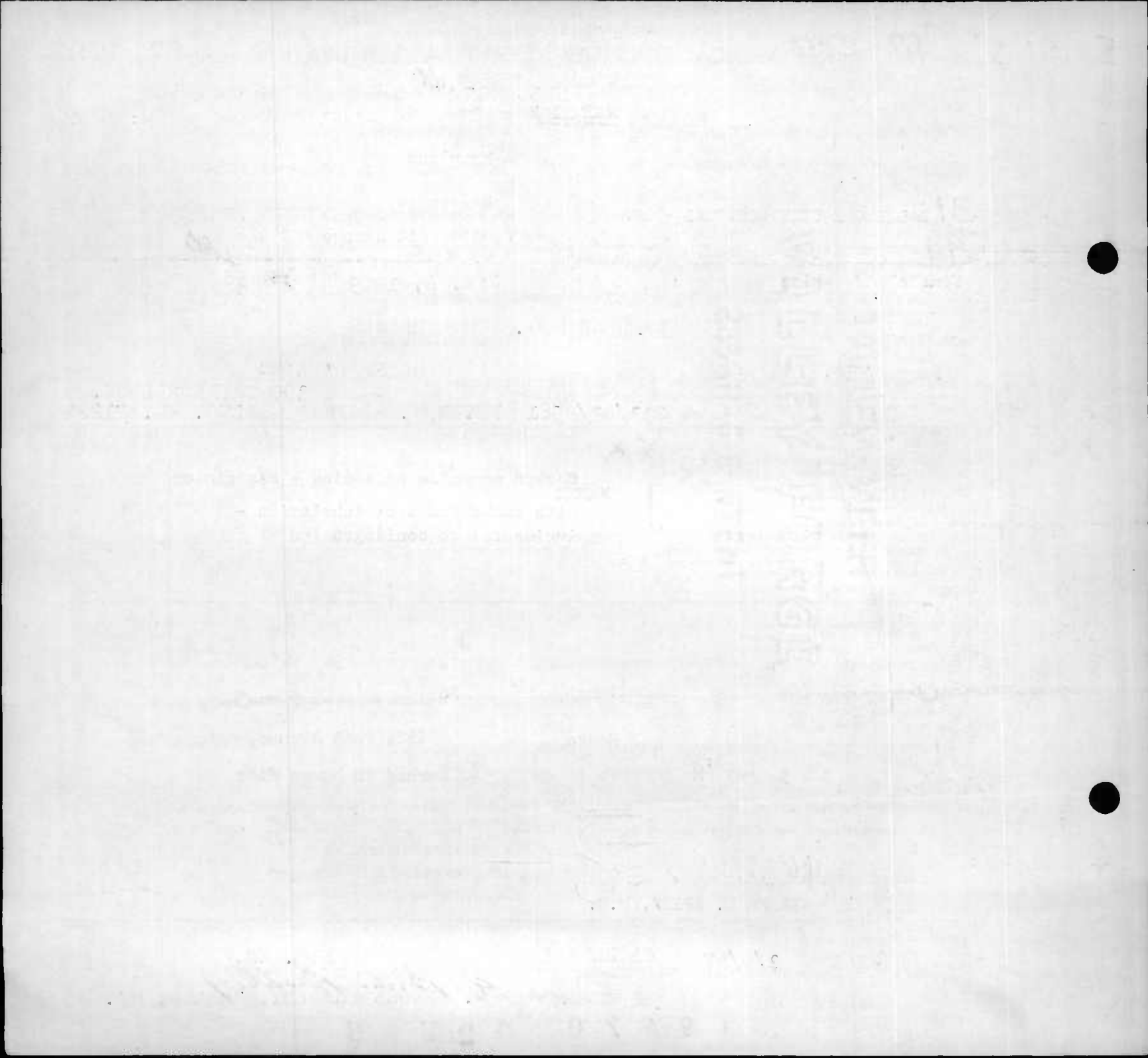
24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

D. BROOKS BRADLEY, DUNDALK, MD.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2298 | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. 67 2298 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Edward R. L. Clary | | 2. DATE AND HOUR OF DEATH March 6, 1967 12:10 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 1504 Belt St. | | A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 24-04 D. STREET ADDRESS (If rural, give location) 1504 Belt St. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH Feb. 21, 1922 | 9. AGE (In years last birthday) 45 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co. | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME George E. Clary | | | |
| 14. MOTHER'S MAIDEN NAME Frances Burke | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes # 2 | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. Charles C. Evans 1504 Belt St. | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 20 1967 to Mar. 6 1967 , that (I) (we) last saw the deceased alive on March 5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Vincent M. Messina | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3-7-67 | |
| 23C. PHYSICIAN'S NAME (Type) Vincent M. Messina | | 23D. ADDRESS 1403 S Charles St | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3 9 1967 | | 24C. NAME OF CEMETERY or CREMATORY Balto. U. S. National | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fajana | | 25C. FUNERAL DIRECTOR Mc Cully | | ADDRESS 130 E. Fort Ave | |

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1903 2 CHARTS

Vertical text, possibly a date or reference number.

Handwritten text, possibly a signature or name.

Handwritten text, possibly a signature or name.

Handwritten text, possibly a signature or name.

Handwritten text, possibly a signature or name.

Handwritten text, possibly a signature or name.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

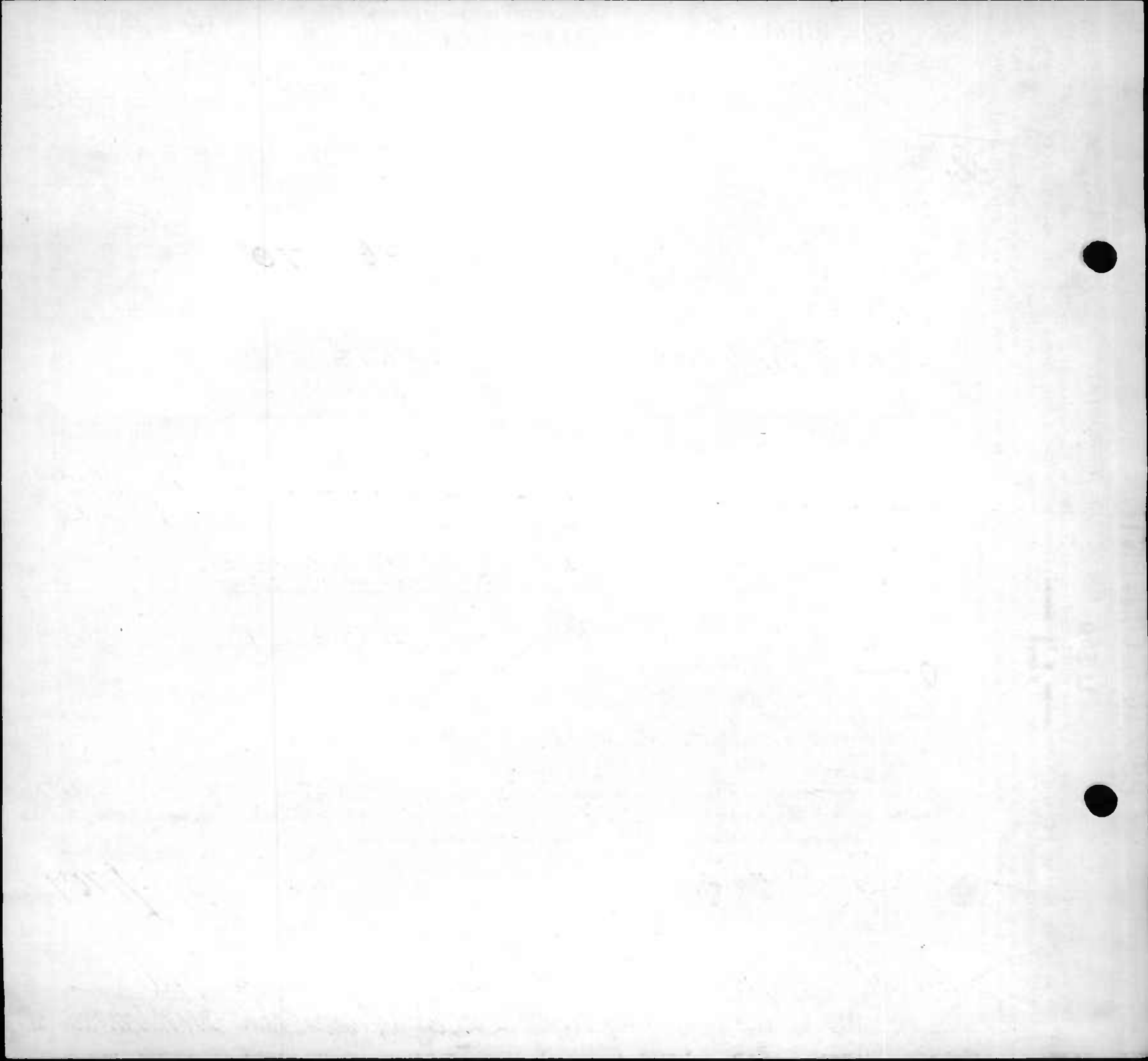
THE UNION NATIONAL HOSPITAL

PHILADELPHIA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2300</u> | |
|---|--|---|--|--|--|
| BIRTH NO. <u>67 2300</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>SAMUEL WILLIAMS</u> | | | | <u>3/6/67</u> <u>16 20</u> A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>38 UNIVERSITY HOSPITAL</u> <u>BALTO., MD</u> | | | | A. STATE <u>MD.</u> B. COUNTY | |
| 5. SEX <u>M</u> 6. RACE <u>N</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u> | | | | 8. DATE OF BIRTH <u>8/28/96</u> 9. AGE (In years last birthday) <u>70</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John Williams</u> | | | | 14. MOTHER'S MAIDEN NAME <u>FANNIE</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>MARY REDD (DAUGHTER)</u> | | | | ADDRESS | |
| 18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <u>ASPIRATION PNEUMONIA</u> DUE TO (B) <u>PNEUMOCOCCAL PNEUMONIA</u> DUE TO (C) <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO (D) <u>ATHEROSCLEROSIS, CEREBRAL + CORONARY HEART DISEASE</u> | |
| | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>14 DAYS</u> <u>14 DAYS</u> <u>—</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <u>PULMONARY EDEMA</u> <u>1</u> <u>12 DAYS</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>(this hospital)</u> attended the deceased from <u>2/20</u> 19 <u>67</u> to <u>3/6</u> 19 <u>67</u> , that <u>(we)</u> last saw the deceased alive on <u>3/6</u> 19 <u>67</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(We)</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Long D. P. Thomas</u> | | | | 23B. DATE SIGNED <u>3/6/1967</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>University Hospital</u> | | | | 23D. ADDRESS <u>University Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/9/67</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Western Star Cem.</u> | |
| 24D. LOCATION <u>Catonville Md.</u> | | 24E. LOCATION (City, town, or county) <u>Catonville Md.</u> | | 24F. LOCATION (State) <u>Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 8 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u> | |
| | | | | ADDRESS <u>319 N. Schraden St.</u> | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 2301**BIRTH NO. **67 2301**
M.E. CASE NO.1. NAME OF DECEASED
(Type or Print)**JOSEPH MC CALLUM**

2. DATE AND HOUR PRONOUNCED DEAD

March 3, 1967 12:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

31 Baltimore City Hospital4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY**Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1033 N. Bond Street

5. SEX

Male

6. RACE

Negro7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)**Married**

8. DATE OF BIRTH

Oct. 13, 19309. AGE (In years
last birthday)**36**If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Laborer**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Robinson Co. N.C.12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Ernest McCallum

14. MOTHER'S MAIDEN NAME

Lucy Bridges15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**No**16. SOCIAL
SECURITY NO.**239-541186**

17. INFORMANT

Beatrice McCallum

ADDRESS

2802XDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)CAUSE OF DEATH
**Wound infection complicating compound
comminuted fractures of right tibia
and fibula**INTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.**Hypertensive and arteriosclerotic
cardiovascular disease**

MEDICAL CERTIFICATION

19A. DATE OF OPERATION
1-20-67 and 3-3-6719B. CONDITION FOR WHICH OPERATION
WAS PERFORMED
leg injury

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?**Yes**21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)
Railroad tracks

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

About 3 blocks west of Newkirk Avenue21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
1-19-67 6:30 P.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

**Leg apparently
run over by train.**

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)**Charles S. Springate, M.D.**CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 4, 196723A. BURIAL CREMATION,
REMOVAL (Specify)**Shipped**

23B. DATE

3/9/1967

23C. NAME OF CEMETERY or CREMATORY

Fairmount N.C.

23D. LOCATION

Fairmount N.C.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 8 1967

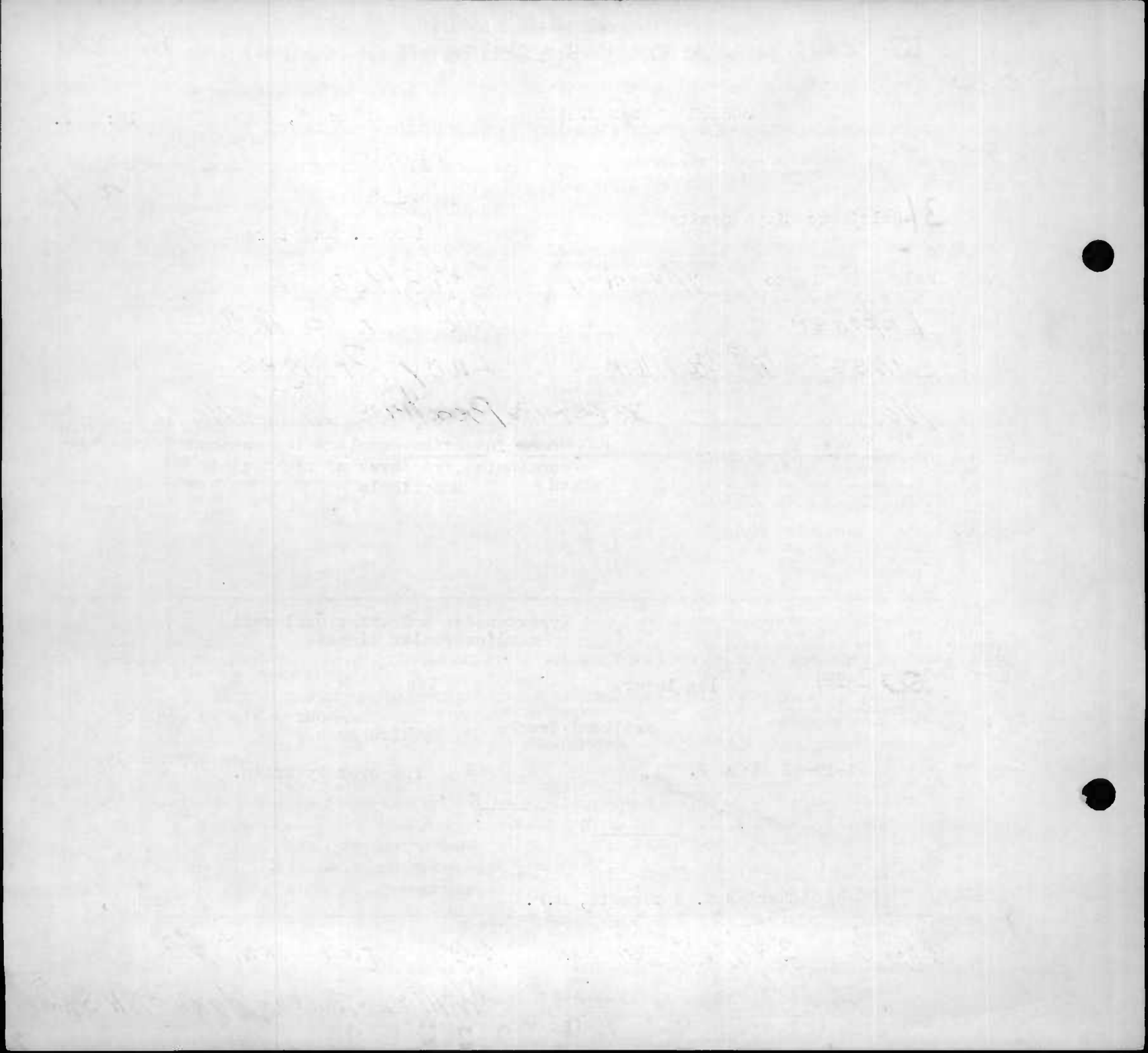
24B. NAME OF REGISTRAR

Paul E. Farkas

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Schroeder St.

ADDRESS



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2302

BIRTH NO. 2302
M.E. CASE NO.1. NAME OF DECEASED
(Type or Print)

GRACIE DAVIS

2. DATE AND HOUR PRONOUNCED DEAD

3-5-67 5:58 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

746 Pennsylvania Avenue - Amb. Crew #1

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

746 Pennsylvania Avenue 21201

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

Oct. 22, 1902

9. AGE (In years
last birthday)

64

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Oxford N.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Squire Rome

14. MOTHER'S MAIDEN NAME

Mollie Perkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

216-16-3087

17. INFORMANT

Agnes Wilson

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-6-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/11/1967

23C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem.

23D. LOCATION

Cedar Hill Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 8 1967

24B. NAME OF REGISTRAR

R. E. Farber

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Schroeder St.

ADDRESS

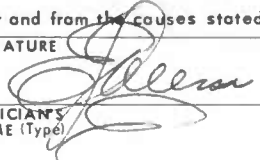
WALLEY FORGE

WALLEY FORGE

WALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

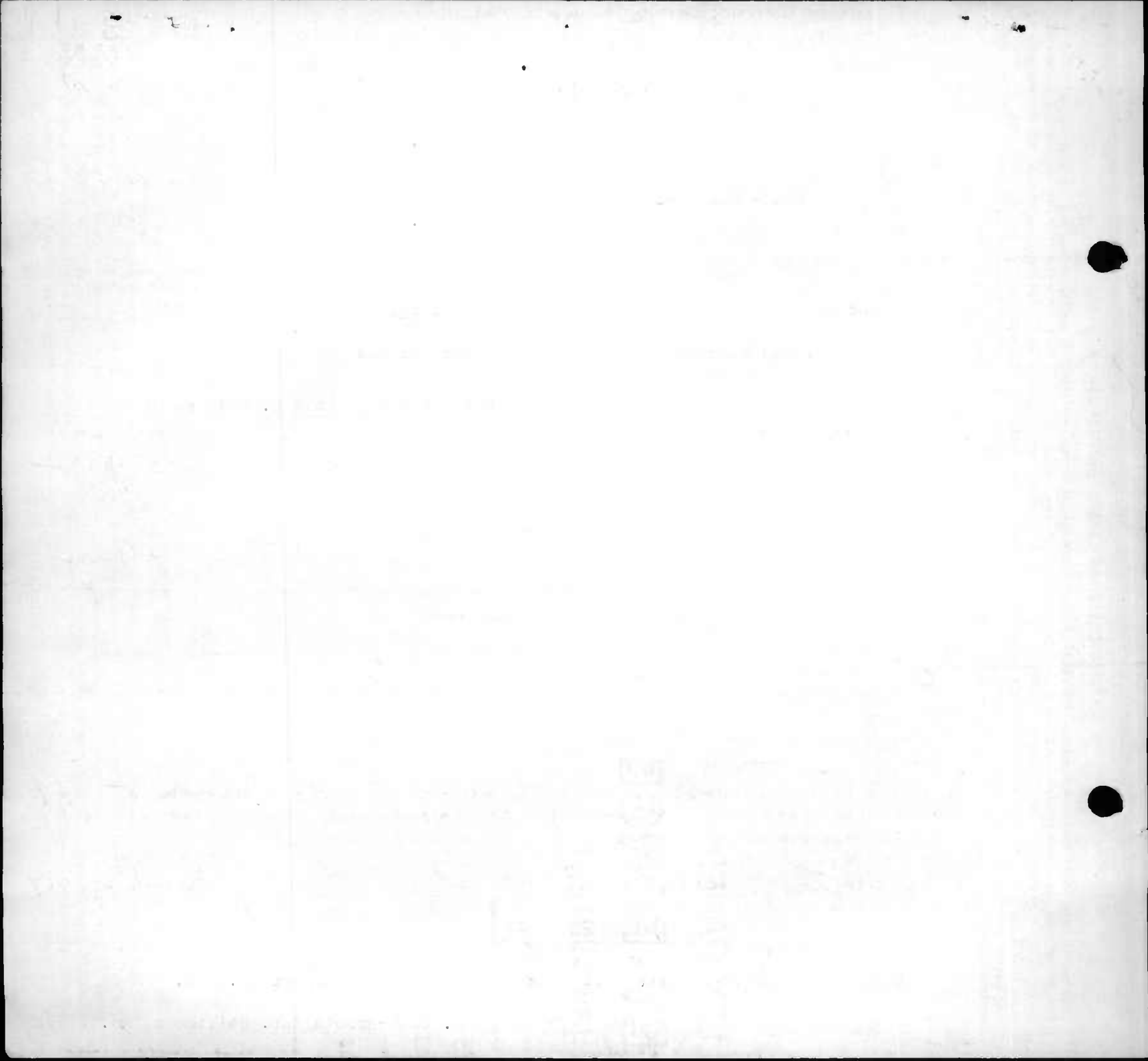
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. | |
|--|------------------|---|------------------------------------|--|----------------------------|--|-----------------------------|
| BIRTH NO. | | 67 2303 | | CERTIFICATE OF DEATH | | 67 2303 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Lillian M. Lucchesi | | | | 3/3/67 7:30 AM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital | | | | A. STATE Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 27-34 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 6118 Fairdell Ave 21206 | | | |
| | | | | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Sept. 23, 1894 | 9. AGE (In years lost birthday) 72 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) not employed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Charles Myers | | | | 14. MOTHER'S MAIDEN NAME Mary Blanche Baugher | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 217-16-4944 | | 17. INFORMANT ADDRESS Mrs. Marie B. Cuddy Same as 4-A, C, D | | | |
| 18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) DUE TO Arteriosclerotic Cardiovascular disease | | 5 yrs | |
| | | | | (B) DUE TO Parkinsonism | | 1 yr. | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 18 1963 to March 3 1967, that (I) (we) last saw the deceased alive on March 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE  | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/6/67 | |
| 23C. PHYSICIAN'S NAME (Type) J. J. E. Fairman | | | | 23D. ADDRESS M.D. 6217 Harford Rd Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-6-67 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 8 1967 | | 25B. NAME OF REGISTRAR J. J. E. Fairman | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson | | ADDRESS 1050 York Road Towson, Maryland 21204 | |

1010

FUNERAL DIRECTOR: IMPORTANT

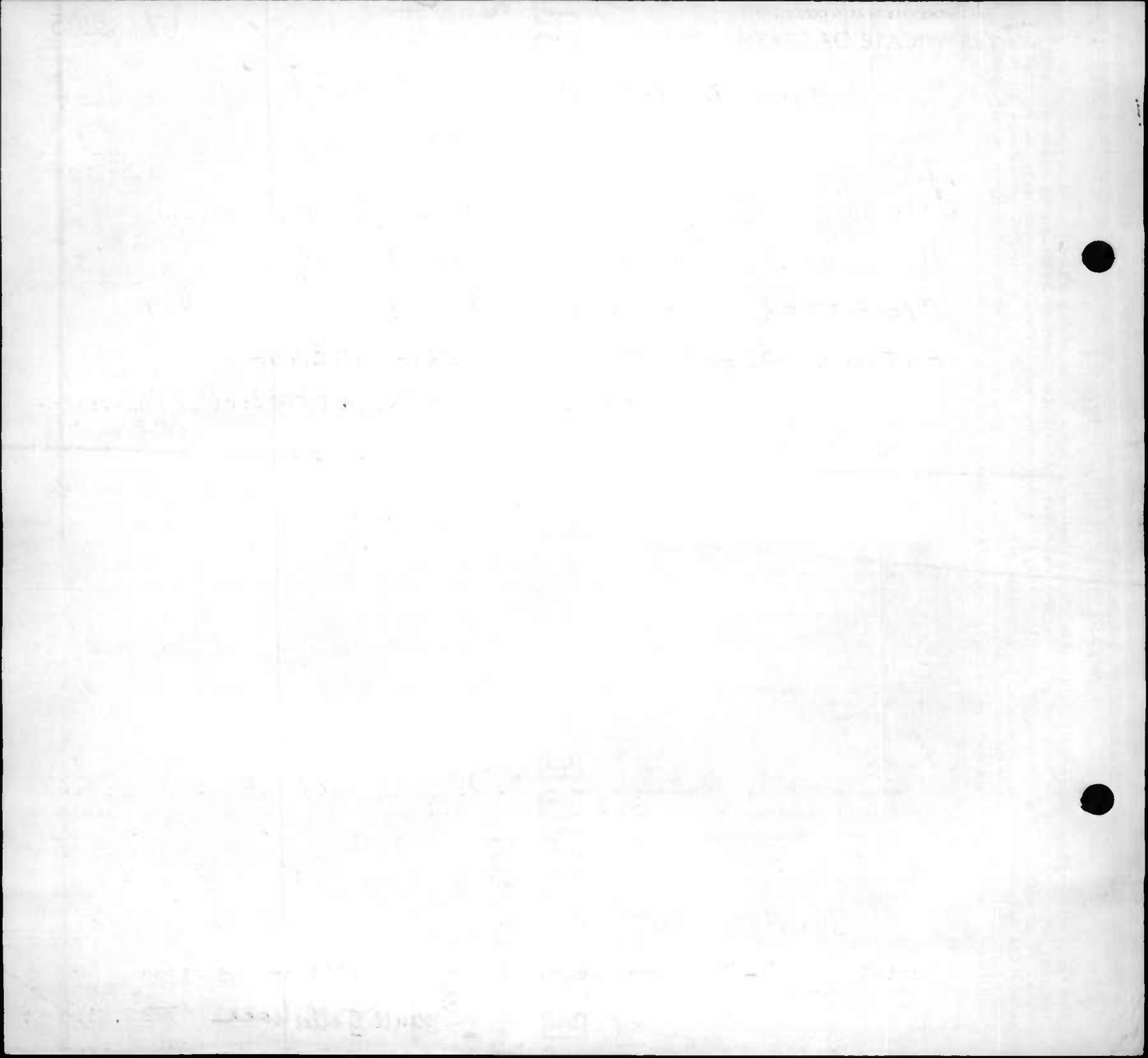
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2304 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2304 | |
|---|---------|--|------------------|---|--|--|------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| ANTHONY DAOUTIS (DANDY) | | | | 3/5/67 9 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION DOA - Union Memorial Hosp | | | | A. STATE Md. B. COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 2634 N. Charles | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
| Male | White | Married | 12/25/94 | 72 | Retired | Greece | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| | | | | ? | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Milton Daoutis | | | | Mary Pappas | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| | | | | | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| Penelope Dandy | | | | 2634 N. Charles St | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| | | | | Coronary Sclerotic Heart Disease | | | |
| | | | | Diabetes Mellitus | | | |
| | | | | Interval between onset and death | | | |
| | | | | 15 years | | | |
| | | | | 14 years plus | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 24 1953 to March 5 1967, that (I) (we) last saw the deceased alive on January 25 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| W. Grafton Herberger M.D. | | | | March 6, 1967 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| | | | | M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 3/8/67 | | Greek Orthodox | | Baltimore Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| | | MAR 8 1967 | | Wm. Cook-Brooks Inc. Baltimore, Md. 21202 | | | |



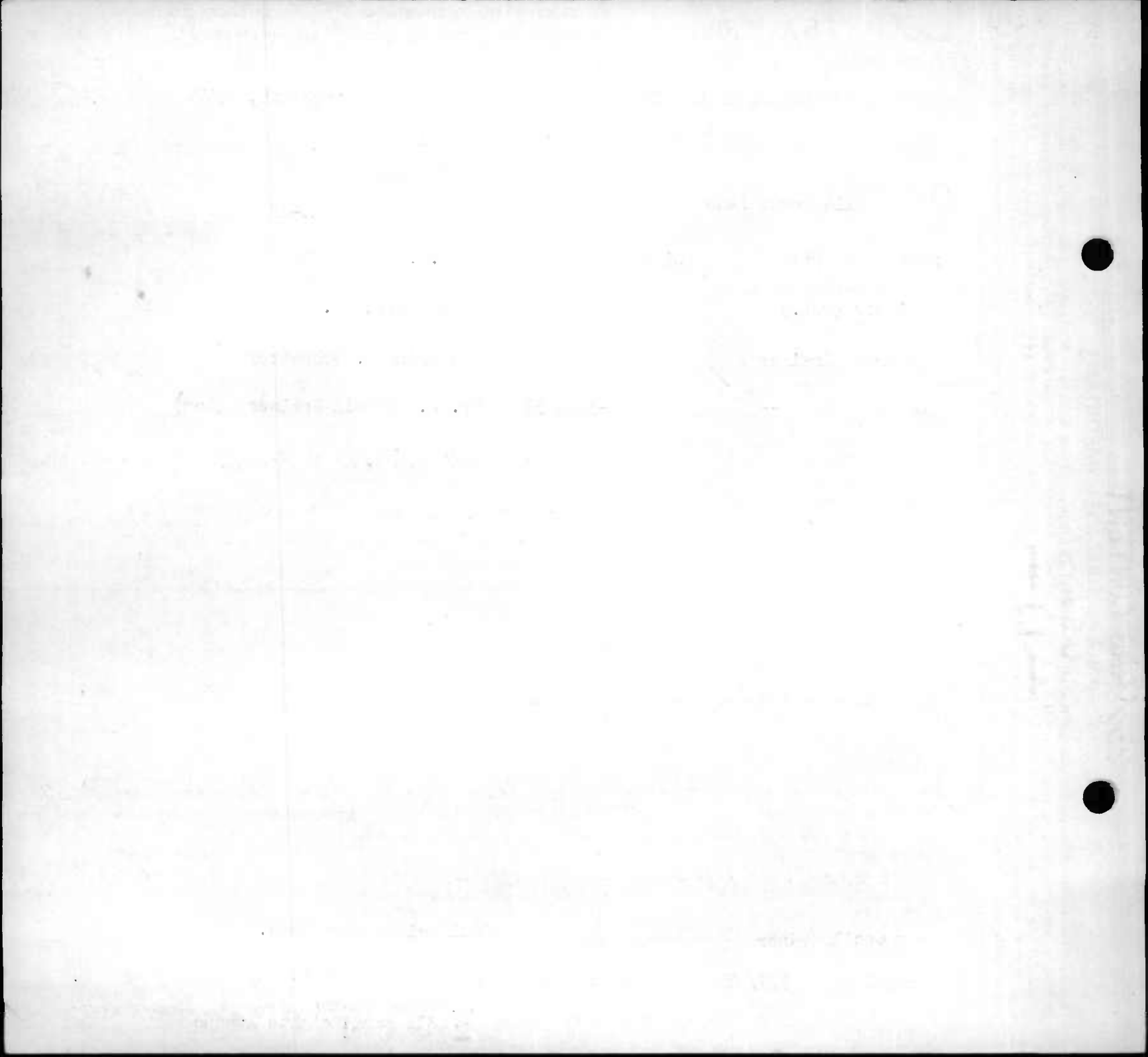
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--|--|--|--|--|
| BIRTH NO. 67 2305 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2305 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) SUGAMOSTO VINCENT | | 2. DATE AND HOUR OF DEATH 3-6-67 1950 | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. Co | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) NORTH CHARLES GENERAL HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00 | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | |
| 8. DATE OF BIRTH 3-10-77 | | 9. AGE (In years last birthday) 89 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPE FITTER | |
| 11. BIRTHPLACE (State or foreign country) ITALY | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME ANTONIO SUGAMOSTO | |
| 14. MOTHER'S MAIDEN NAME MARIA MENNA | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 215-34-7880 | |
| 17. INFORMANT LOUIS PROIETTI-8360 OLD PHILADELPHIA | | ADDRESS 1RD. | | 18. CAUSE OF DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (A) DUE TO CARCINOMA OF STOMACH | | (B) DUE TO SEVERE ANEMIA | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 6 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-25-67 to 3-6-67 and that (I) (we) last saw the deceased alive on 3-6-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Alejandro Montoya | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3-6-67 | |
| 23C. PHYSICIAN'S NAME (Type) ALEJANDRO MONTOYA | | 23D. ADDRESS M.D. NORTH CHARLES GENERAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/9-67 | | 24C. NAME OF CEMETERY or CREMATORY Sacred Heart of Mary | |
| 24D. LOCATION Baltimore Md 21222 | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR | | ADDRESS 322 S. High St | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2306 | |
|---|-------------------------|---|--|---|--|
| BIRTH NO. 67 2306 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH March 4th 1967 9 24/A M. | | | |
| 1. NAME OF DECEASED (Type or Print) HOWARD GEORGE KREINER | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 4114 Fords Lane | | D. STREET ADDRESS (If rural, give location) 4114 Fords Lane-15 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED Widowed | 8. DATE OF BIRTH Sept. 8, 1887 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder (ret.) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Charles Kreiner | | 14. MOTHER'S MAIDEN NAME Katherine F. Schwetzer | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no -- | | 16. SOCIAL SECURITY NO. 212-32-4836 | | 17. INFORMANT ADDRESS Mr. J. Carroll Kreiner (Son) | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction | | CAUSE OF DEATH (A) DUE TO Anteroseptal Cardiovascular Disease | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Vascular Disease | | (C) _____ | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from November 1962 to March 4 1967 , that (I) (we) last saw the deceased alive on March 4 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Cecil Rudner | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3-6-67 | |
| 23C. PHYSICIAN'S NAME (Type) Cecil Rudner | | 23D. ADDRESS M.D. 6821 Reisterstown Road. | | | |
| 24A. BURIAL CREMATION, DATE OF REMOVAL (Specify) Burial 3/7/67 | | 24C. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 25B. NAME OF REGISTRAR Robert E. Sullivan | | 25C. FUNERAL DIRECTOR ADDRESS C. Vernon Lemmon 2461 Park Heights Avenue | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2307</u> | |
|---|---------------------|---|---------------------------------------|---|--|
| BIRTH NO. <u>67 2307</u> | | | | CERTIFICATE OF DEATH | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>DeWitt-Mrs. DeLilah Habliston</u> | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH <u>March 8, 1967</u> <u>3⁴⁰</u> <u>A.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>91</u> <u>"Keswick"</u> <u>700 W. 40th Street</u> | | A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>700 W. 40th Street</u> <u>426 Rosebank Av.</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>12-16-1885</u> | 9. AGE (In years last birthday) <u>81</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND (Balto.)</u> | |
| 13. FATHER'S NAME <u>Charles C. Habliston</u> | | 14. MOTHER'S MAIDEN NAME <u>Helen J. Wallace</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-20-7966</u> | | 17. INFORMANT son: <u>Chas. DeWitt, 3rd</u> ADDRESS <u>21204 438 Range Rd.</u> | |
| 18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Cerebrovascular Accident</u> DUE TO (B) <u>Arteriosclerotic Cerebrovascular disease</u> DUE TO (C) <u>Arteritis, rheumatoid vessels</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>11 days 58 yrs</u> <u>12 yrs</u> <u>5 yrs.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2-15-1965</u> to <u>3-8-1967</u> , that (I) (we) last saw the deceased alive on <u>3-8-1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>A. Richardson</u> | | | | 23B. DATE SIGNED <u>3-8-1967</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Aubrey D. Richardson</u> | | 23D. ADDRESS M.D. <u>700 W. 40th Street</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>CREMATION</u> | | 24B. DATE <u>3/8/67</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Green Mount Crematory</u> | |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1967</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>Stewart & Mowen Co. 108 W. North Av. City</u> | | | |

1. The first part of the paper is devoted to a general discussion of the problem.

2. In the second part, we shall consider the special case of a uniform distribution.

3. The third part is devoted to the study of the asymptotic behavior of the distribution.

4. In the fourth part, we shall discuss the problem of the estimation of the parameters.

5. The fifth part is devoted to the study of the properties of the estimators.

6. In the sixth part, we shall consider the problem of the construction of confidence intervals.

7. The seventh part is devoted to the study of the asymptotic behavior of the confidence intervals.

8. In the eighth part, we shall discuss the problem of the estimation of the variance.

9. The ninth part is devoted to the study of the properties of the estimators of the variance.

10. In the tenth part, we shall consider the problem of the construction of confidence intervals for the variance.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2308BIRTH NO. 67 2308

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)RUSSELL H. JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

March 3, 1967 8:05 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Maryland General Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTYMaryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

504 St. Mary Street

5. SEX

Male

6. RACE

Negro7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)Widowed

8. DATE OF BIRTH

1/27/179. AGE (In years
last birthday)50If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Contractors

11. BIRTHPLACE (State or foreign country)

VA.12. CITIZEN OF
WHAT COUNTRY?U.S.A.

13. FATHER'S NAME

Walter Johnson

14. MOTHER'S MAIDEN NAME

Katie Johnson15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)no16. SOCIAL
SECURITY NO.unknown

17. INFORMANT

ADDRESS

Elvie Johnson - 462 Clason Ave. Brooklyn, N.Y.

18.

420.07T E 983X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic heart disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.Lacerations and abrasions of head

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

219B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)street21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?30 feet east of
548 W. Biddle Street21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

3-3-677:40 P.m. WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

Chased and
assaulted by three men

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)Charles S. Springate, M.D.M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐March 4, 196723A. BURIAL CREMATION,
REMOVAL (Specify)Burial

23B. DATE

3/9/67

23C. NAME OF CEMETERY or CREMATORY

mt. Auburn

23D. LOCATION

(City, town, or county)

(State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

MAR 9 1967

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. L. Chatman P-12017 M^{rs} Cullen St

ADDRESS

Balto. Md.

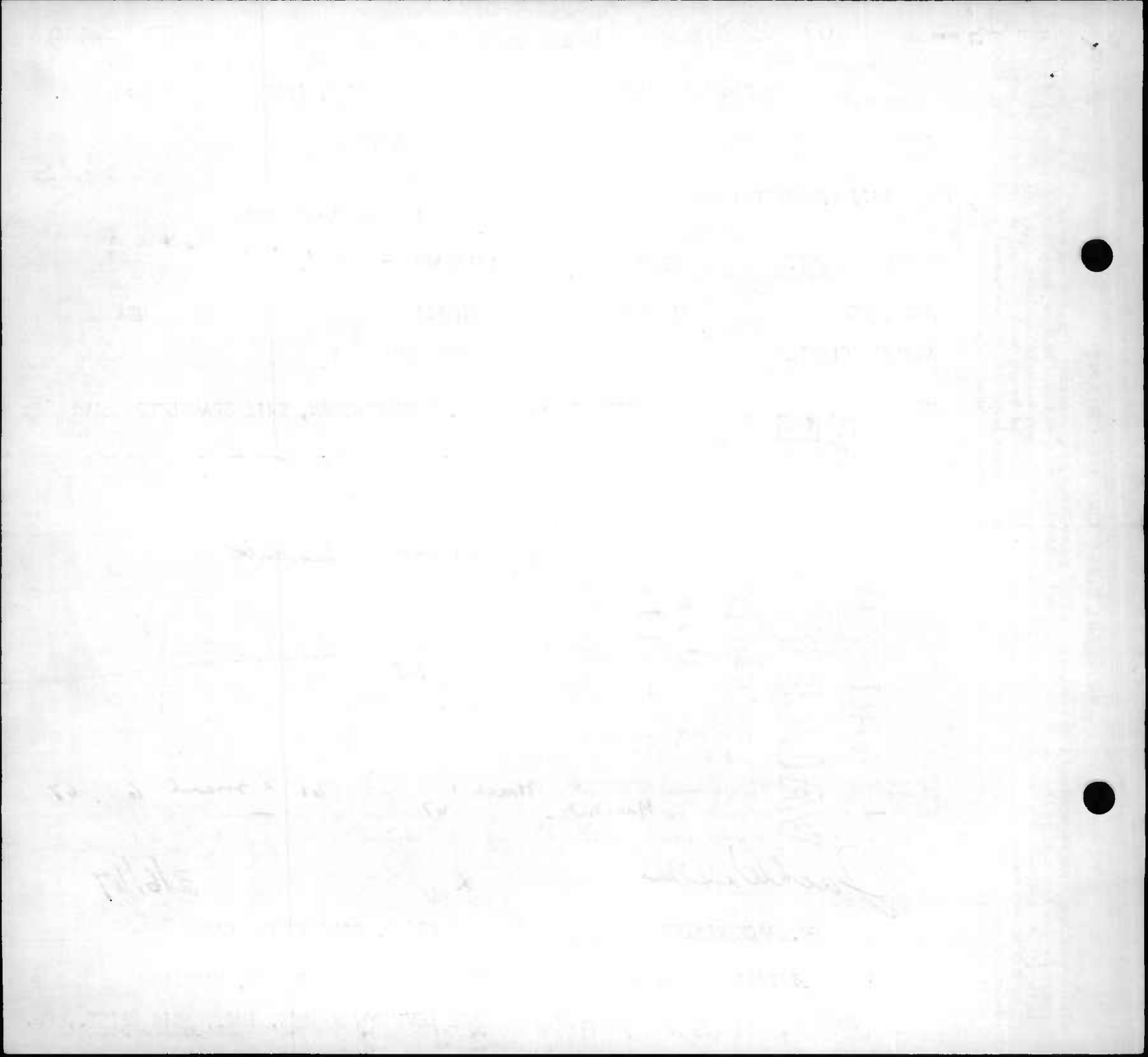
1/2/10
Kati Johnson
1/2/10

1/2/10
Kati Johnson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

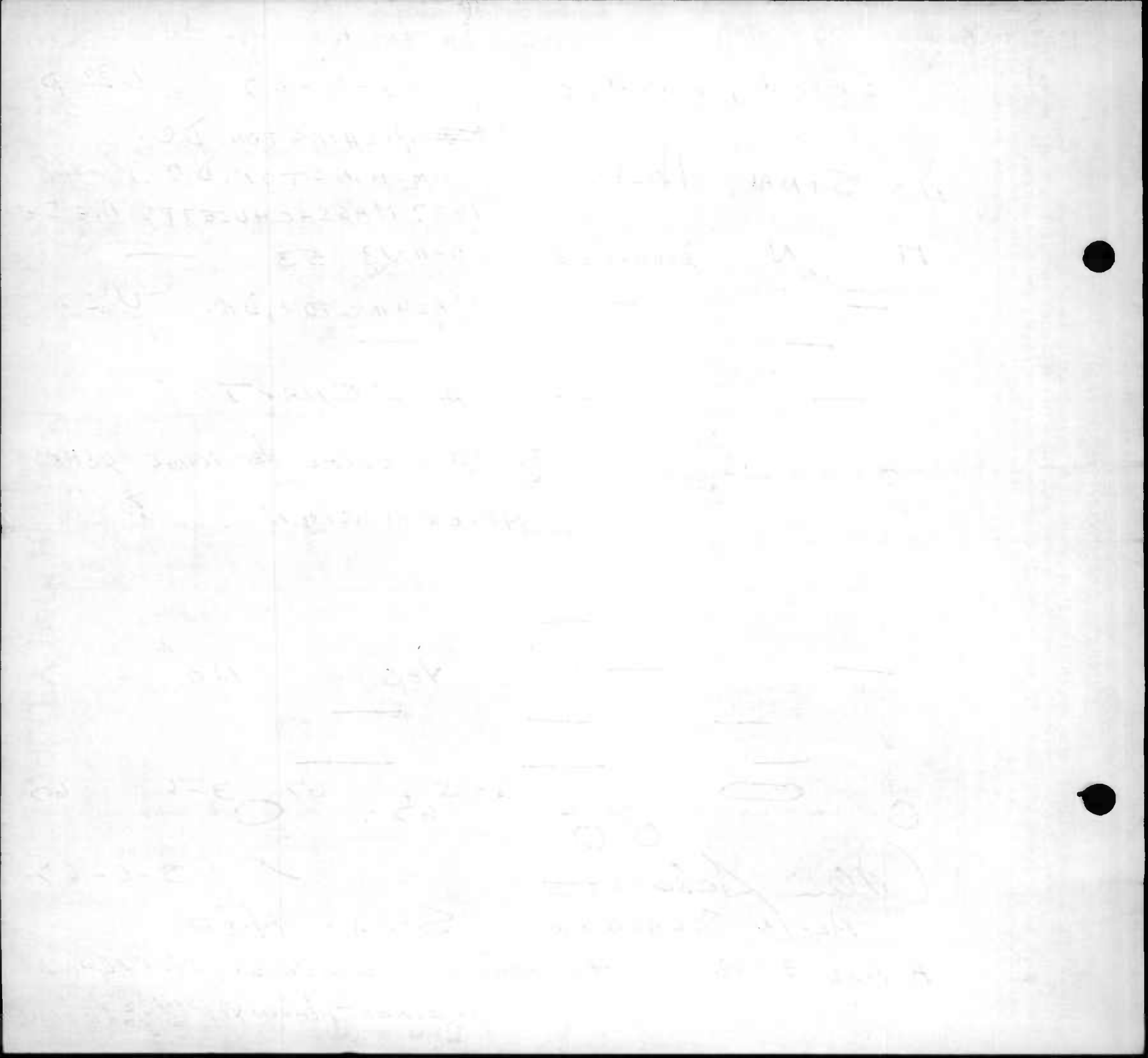
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2309 | |
|--|---------------|--|---------------------------|---|---|
| BIRTH NO. 67 2309 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARY CLUSTER GOLDSTEIN | | | |
| 2. DATE AND HOUR OF DEATH | | MARCH 6, 1967 3:45 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | | |
| 00 2412 BRAMBLETON ROAD | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 27-15 | | | |
| | | D. STREET ADDRESS (If rural, give location) 2412 BRAMBLETON ROAD | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH 1/1/1884 | 9. AGE (In years last birthday) 83 | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) RUSSIA | |
| 13. FATHER'S NAME ABRAHAM CLUSTER | | 14. MOTHER'S MAIDEN NAME AVA REVA ? | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT ADDRESS MRS. IRVING HYMAN, 2412 BRAMBLETON ROAD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenio, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | | |
| 332X 1-260X | | (A) Cerebral Thrombosis | | | |
| ANTECEDENT CAUSES | | (B) Arteriosclerosis | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (C) Hypertension + Diabetes | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 1 1967 to March 6 1967, that (I) (we) last saw the deceased alive on March 3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE DR. JACK WEXLER | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/6/67 | |
| 23C. PHYSICIAN'S NAME (Type) DR. JACK WEXLER | | 23D. ADDRESS M.D. 222 W. COLD SPRING LANE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/7/67 | | 24C. NAME OF CEMETERY or CREMATORY BETH HAMEDROSH HAGODOL | |
| 24D. LOCATION BALTIMORE, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REIST., RD. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|---------------------|---|-------------------------------------|---|---|
| BIRTH NO. 67 2310 | | CERTIFICATE OF DEATH | | 67 2310 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JETER, ARTHUR | | 2. DATE AND HOUR OF DEATH 3-6-67 6:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSP. | | A. STATE WASHINGTON, D.C. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) WASHINGTON, D.C. V-48 D. STREET ADDRESS (If rural, give location) 1627 MASSACHUSETTS AVE S.E. | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED | 8. DATE OF BIRTH 12-11-13 | 9. AGE (In years last birthday) 53 | 10. CITIZEN OF WHAT COUNTRY? U.S. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS HOSP. CHART. | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) INTRA CEREBRAL HEMORRHAGE 48 HRS. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO HYPERTENSION | | ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-5-1967 to 3-6-1967 , that (I) (we) last saw the deceased alive on 3-6-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 21F. HOW DID INJURY OCCUR? | | | |
| 23A. SIGNATURE Alvin Schachter M.D. | | 23B. DATE SIGNED 3-6-67 | | | |
| 23C. PHYSICIAN'S NAME (Type) ALVIN SCHACHTER M.D. | | 23D. ADDRESS SINAI HOSP | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-11-1967 | | 24C. NAME OF CEMETERY OR CREMATORY HARMONY | |
| 24D. LOCATION (City, town, or county) (State) LANDOVER, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 25B. NAME OF REGISTRAR W. ERNEST JARVIN | |
| 25C. FUNERAL DIRECTOR ADDRESS 1432 YOU STREET, N.W. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|------------------|--|--|--|--|
| BIRTH NO. Balto. Co., Md. 67 2311 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2311 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Jon Randall Click | | (Son Randall Click) | | 2. DATE AND HOUR OF DEATH March 7, 1967, 12:01 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Harford Co | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 93 Happy Hills Hospital 1708 W. Rogers Ave. Balto, Md. 21209 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Bel Air | | | |
| | | D. STREET ADDRESS (If rural, give location) 208 E. Heather Rd. | | 62-32 | |
| 5. SEX Male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH 12/26/66 | 9. AGE (In years last birthday) 2 | 10. If Under 1 Yr. Months: Days 7 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | 10B. KIND OF BUSINESS OR INDUSTRY 0 | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Palmer Click | | 14. MOTHER'S MAIDEN NAME Mary Louise Berkemeyer | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 0 | 17. INFORMANT (Father) 838-6086 Mr. Palmer L. Click | | ADDRESS 208 E. Heather Rd. Bel Air, Maryland 21014 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 762.01 | | CAUSE OF DEATH (A) Probable aspiration pneumonia minutes DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first. | | (B) severe brain damage DUE TO | | 2 months, 7 days | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | (C) prolonged 19 1/2° apnea following birth | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 0 | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 1, 1967 to March 7, 1967, that (I) (we) last saw the deceased alive on March 6, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Allan J. Monfried | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/7/67 | |
| 23C. PHYSICIAN'S NAME (Type) Allan J. Monfried | | 23D. ADDRESS Sinai Hospital of Balto. Balto., Md. 21215 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Mar. 8, 1967 | | 24C. NAME OF CEMETERY or CREMATORY Bel Air Memorial Gardens | |
| | | 24D. LOCATION Bel Air, Harford Co., Maryland 21014 | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 25B. NAME OF REGISTRAR Philip E. Fisher | | 25C. FUNERAL DIRECTOR Joseph William Foster | |
| | | ADDRESS W. Broadway & Williams Bel Air, Maryland 21014 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2312 | |
|--|----------------------|--|----------------------------------|--|---|
| BIRTH NO. 67 2312 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BAUER, MARY A. | | | |
| 2. DATE AND HOUR OF DEATH | | MARCH 4, 1967 9:40P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL (If not in hospital or institution, give street address or location) WILKENS & CATON AVENUE BALTIMORE, MARYLAND 21229 | | A. STATE MARYLAND B. COUNTY BALTIMORE Co. | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 21228 53.00 | | D. STREET ADDRESS (If rural, give location) 19 DUNMORE RD., CATONSVILLE | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 07-08-83 | 9. AGE (in years, lost birthday) 83 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME RUBEN | | 14. MOTHER'S MAIDEN NAME SUSAN (RIALE) | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) NO | | 16. SOCIAL SECURITY NO. 213 10 1300 | | 17. INFORMANT ADDRESS ST. AGNES RECORDS, WILKENS & CATON BALTIMORE, MARYLAND 21229 | |
| 18. 491 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Septicemia | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Bilateral Bronchopneumonia | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Liver Cirrhosis and GI bleeding | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 2, 1967 to MARCH 4, 1967 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on MARCH 4, 1967 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | |
| 23A. SIGNATURE <i>E.H. Weiss</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED MARCH 4, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) E.H. WEISS, M.D. | | 23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON BALTO., MD. 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 7-8-67 | | 24C. NAME OF CEMETERY OR CREMATORY Oakland Cem. | |
| 24D. LOCATION (City, town, or county) Baltimore, Md. | | 24E. FUNERAL DIRECTOR Farley Cavanaugh | | 24F. ADDRESS Frederick Rd. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 25B. NAME OF REGISTRAR R. E. Farley | | 25C. FUNERAL DIRECTOR Farley Cavanaugh | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 67 2313 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | | 67 2313 | |
|--|---------|--|------------------|--|---|---|------------------------------|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| SAMUEL A. JACKSON | | | | MARCH 5, 1967 | | | | 11:35 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | | | B. COUNTY | |
| ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO. 29, MD. | | | | MARYLAND | | | | A.A. Co. | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | PASADENA, RT. #4 BOX 9 | | | | 352-00 | |
| D. STREET ADDRESS (If rural, give location) | | | | 7 PARK DRIVE LAKE SHORE | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. BIRTHPLACE (State or foreign country) | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| MALE | WHITE | MARRIED | 10-14-99 | 67 | MARYLAND | MARYLAND | U.S.A. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | |
| BRAKEMAN | | | | B. & O. RAILROAD | | | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| JOHN JACKSON | | | | HELEN BANNON | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | |
| NO | | | | | | | | ST. AGNES HOSPITAL, WILKENS & CATON AVE. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | | | 21F. HOW DID INJURY OCCUR? | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-3 19 67 to 3-5 19 67, that (I) (we) lost saw the deceased alive on 3-5- 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| DR PABLO DIBOS | | | | March 5, 1967 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| DR PABLO DIBOS | | | | ST. AGNES HOSPITAL, WILKENS & CATON AVE. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | | | Mar. 9, 1967 | | | | Meadowridge Memorial Park | |
| 24D. LOCATION (City, town, or county) (State) | | | | 24E. FUNERAL DIRECTOR | | | | 24F. ADDRESS | |
| Baltimore, Maryland | | | | George J. Gonce, 4001 Ritchie Hwy., Baltimore | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | | 25C. FUNERAL DIRECTOR | |
| MAR 9 1967 | | | | George J. Gonce | | | | | |

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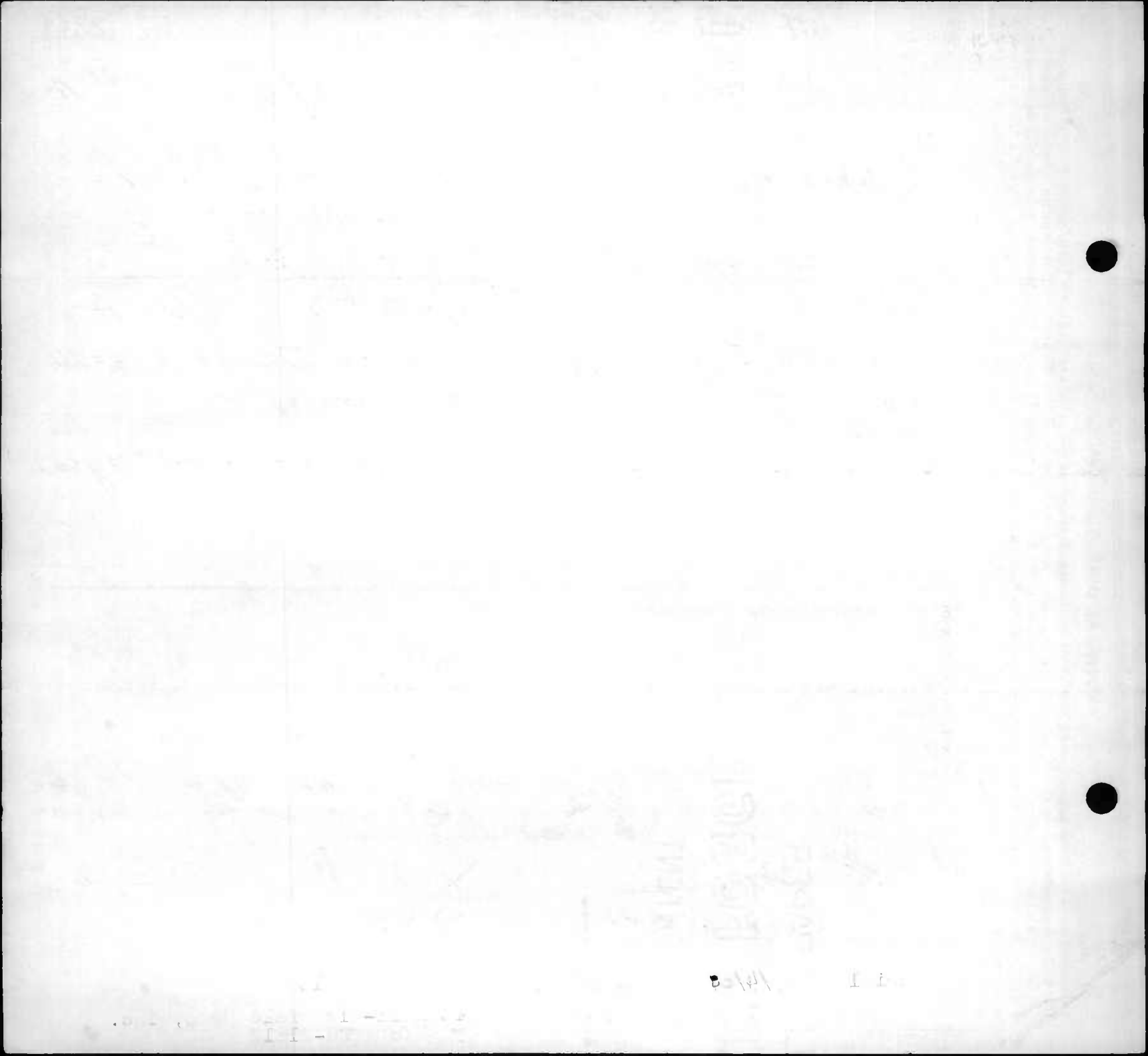
10-11-70

10-11-70

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

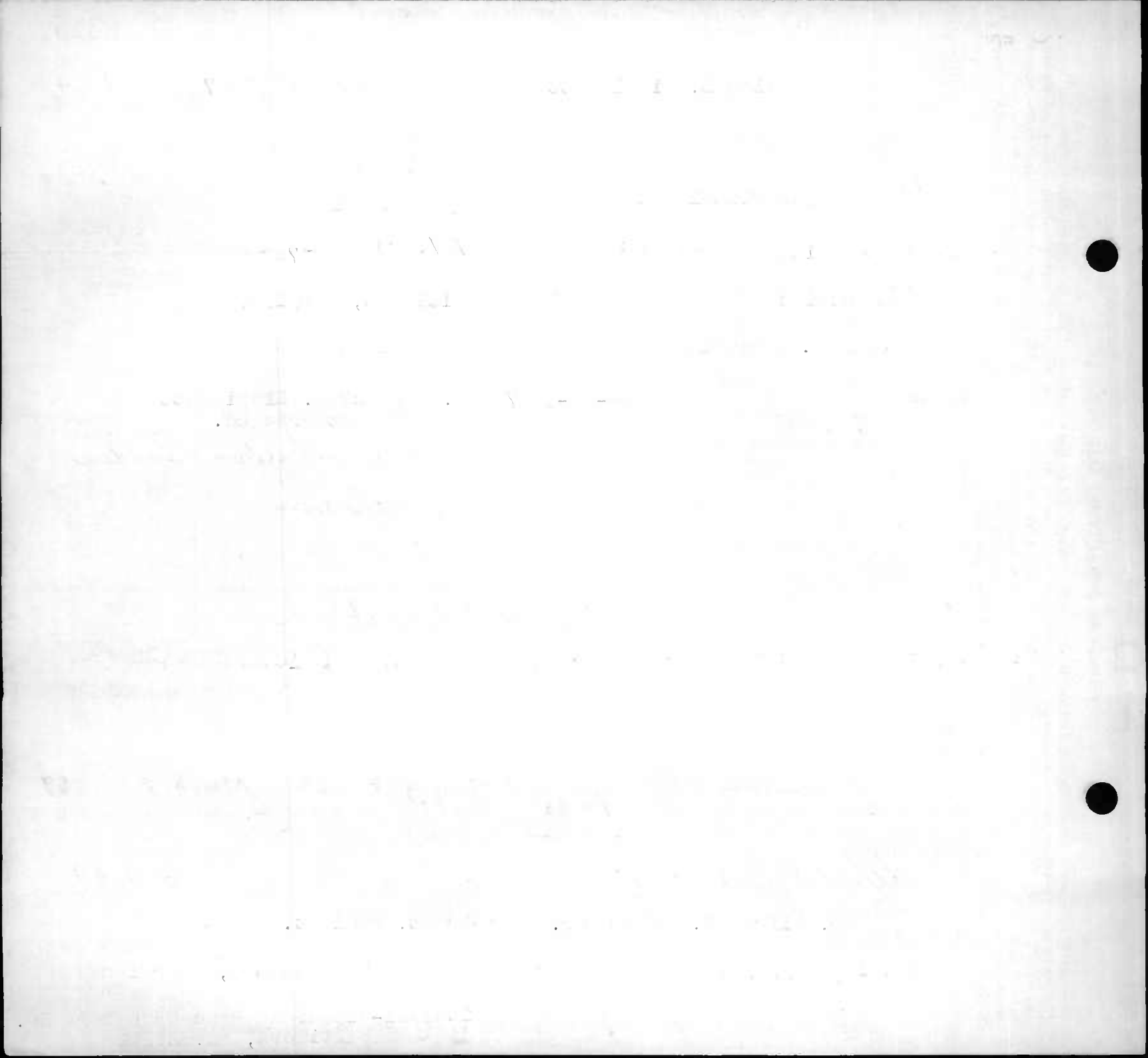
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|-----------|--|------------------|--|---|
| 67 2314 | | CERTIFICATE OF DEATH | | 67 2314 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Johanson, Clarence | | 3/2/67 19 30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | Maryland | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| 33 Johns Hopkins Hospital | | D. STREET ADDRESS (If rural, give location) | | 2024 N. Wolfe Street | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED (specify)) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days If Under 24 Hrs. Hours Min. |
| M | Caucasian | W | 6/24/1900 | 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired | | | | BALTO. MD | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| JOHANN B JOHANSON | | HANNAH SCHUELEBERG | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NLO | | | | HOSP. RECORDS - | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 433.1 I | | atrial fibrillation | | 2 1/2 yrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| O | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/28 1967 to 3/2 19 67, that (I) (we) lost saw the deceased alive on 3/2 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Robb Mases | | | | 3/3/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Robb Mases | | JHH | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3/4/67 | | London Park | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 9 1967 | | E. J. Schuman | | Mitchell-Wiedefeld Home, Inc. 6500 York Rd-21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

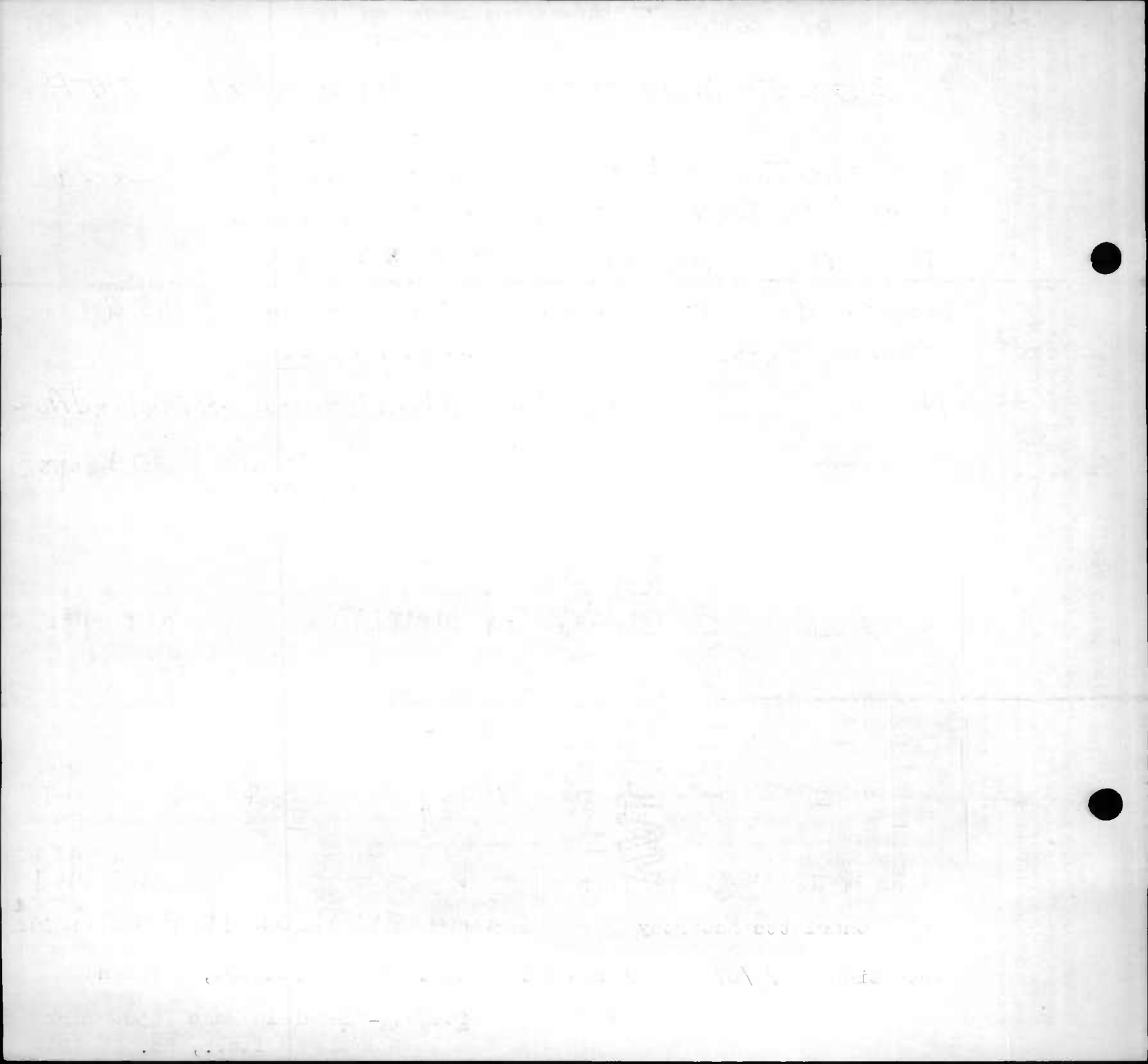
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2315</u> | |
|---|-------------------------|--|---|--|---|
| BIRTH NO. <u>67 2315</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Helen L. Lippincott</u> | | 2. DATE AND HOUR OF DEATH <u>March 5, 1967</u> <u>11 A</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>4512 Wilmslow Road</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | <u>27-14</u> | |
| | | D. STREET ADDRESS (If rural, give location) <u>4512 Wilmslow Road</u> | | | |
| 5. SEX <u>female</u> | 6. RACE <u>white</u> | 7. MARRIED, NEVER MARRIED <u>WIDOWED, DIVORCED (specify)</u> <u>Widowed</u> | 8. DATE OF BIRTH <u>11/2/1890</u> | 9. AGE (In years last birthday) <u>76</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>John A. Lawrence</u> | | | 14. MOTHER'S MAIDEN NAME <u>Eleanor Gould</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>214-30-5217</u> | 17. INFORMANT ADDRESS <u>Mr. Wallace S. Lippincott</u> | | |
| 18. <u>4-20-1</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u> <u>Coronary occlusion</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Essential hypertension</u> | | CAUSE OF DEATH <u>102 Hawthorne Rd.</u> <u>Sudden</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>February 5, 1963</u> to <u>March 5, 1967</u> , that (I) (was) last saw the deceased alive on <u>1-23</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Alfred G. Ossman Jr.</u> M.D. | | | | 23B. DATE SIGNED <u>3-7-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Alfred G. Ossman Jr.</u> M.D. | | | | 23D. ADDRESS <u>1010 St. Paul St.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/8/67</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Loudon Park</u> | |
| | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Md. 21212</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|---------------------|--|---|---|--|----------------------------|---|--|--|--|
| 67 2316 | | | | | 67 2316 | | | | | |
| BIRTH NO. | | | | | Registered No. | | | | | |
| M.E. CASE NO. | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Elizabeth M. Van Horn</u> | | | | | March 2, 1967 8:15 P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 The Taylor Home</u> <u>4608 Roland Ave. Balt. Md</u> | | | | | A. STATE <u>Maryland</u> | | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | | |
| D. STREET ADDRESS (If rural, give location) <u>4608 Roland Ave</u> | | | | | 27-14 | | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>8/16/1883</u> | 9. AGE (In years last birthday) <u>83</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretarial</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Do not know</u> | | 11. BIRTHPLACE (State or foreign country) <u>Bucks Co. Penna</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Joseph Mathews</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Sidney Price</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>216-46-9971</u> | | 17. INFORMANT <u>Mildred D. Rivers</u> | | | ADDRESS <u>4608 Roland Ave</u> | | |
| 18. <u>422.15-260X</u> | | | | | CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) <u>Arteriosclerotic Cardio-vascular disease</u> | | | | | |
| ANTECEDENT CAUSES | | | | | (B) <u>age</u> | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (C) | | | | | |
| II | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | <u>diabetes mellitus</u> | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1940</u> to <u>Feb. 27</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Feb. 27</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <u>Charlotte McCarthy MD</u> M.D. | | | | | | | | 23B. DATE SIGNED <u>March 3, 1967</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Charlotte McCarthy</u> | | | | | 23D. ADDRESS <u>2919 St. Paul St. Baltimore</u> M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 24B. DATE <u>3/3/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Greenmount Crematory</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. <u>MAR 9 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Kelly, M.D.</u> | | | 25C. FUNERAL DIRECTOR <u>Mitchell W. Medefeld</u> | | | ADDRESS <u>6500 York Road Balto., Md. 21212</u> | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 2317 | |
|--|--|---|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| BIRTH NO. 67 2317 | | | | | | | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) DITTY, MARY B. | | | | | | | | 2. DATE AND HOUR OF DEATH MARCH 5th 1967 4:05 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL 44 | | | | | | A. STATE MARYLAND B. COUNTY | | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) 1307 PARK AVENUE | | | | | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 07-11-1883 | | 9. AGE (In years last birthday) 83 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | | 12. CITIZEN OF WHAT COUNTRY? AMERICAN | |
| 13. FATHER'S NAME OWEN C. BLADES | | | | | | 14. MOTHER'S MAIDEN NAME ROADE FOUNTAIN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 081-10-1169B | | 17. INFORMANT Mrs. John M. Snyder | | | | ADDRESS 10004 E. Bexhill Rd. Kensington Md. | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. PERIPHERAL VASCULAR DISEASE & GANGRENE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | | | (A) DUE TO | | 5 DAYS | | | |
| | | | | | | (B) DUE TO | | MANY YEARS | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-27-67 to 3-5-67 , that (I) (we) last saw the deceased alive on 3-5-67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Erik Jofur Bjornsson M.D. | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3-5-67 | |
| 23C. PHYSICIAN'S NAME (Type) Erik Jofur Bjornsson M.D. | | | | | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 3/8/67 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Crematory | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | | | 25B. NAME OF REGISTRAR Robert E. Faldut | | | | 25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Md. 21212 | | | |

OWEN C. BLADES ROBE FORMATION

PNEUMONIA
 BRONCHIAL ASTHMA
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M-600 67 2318

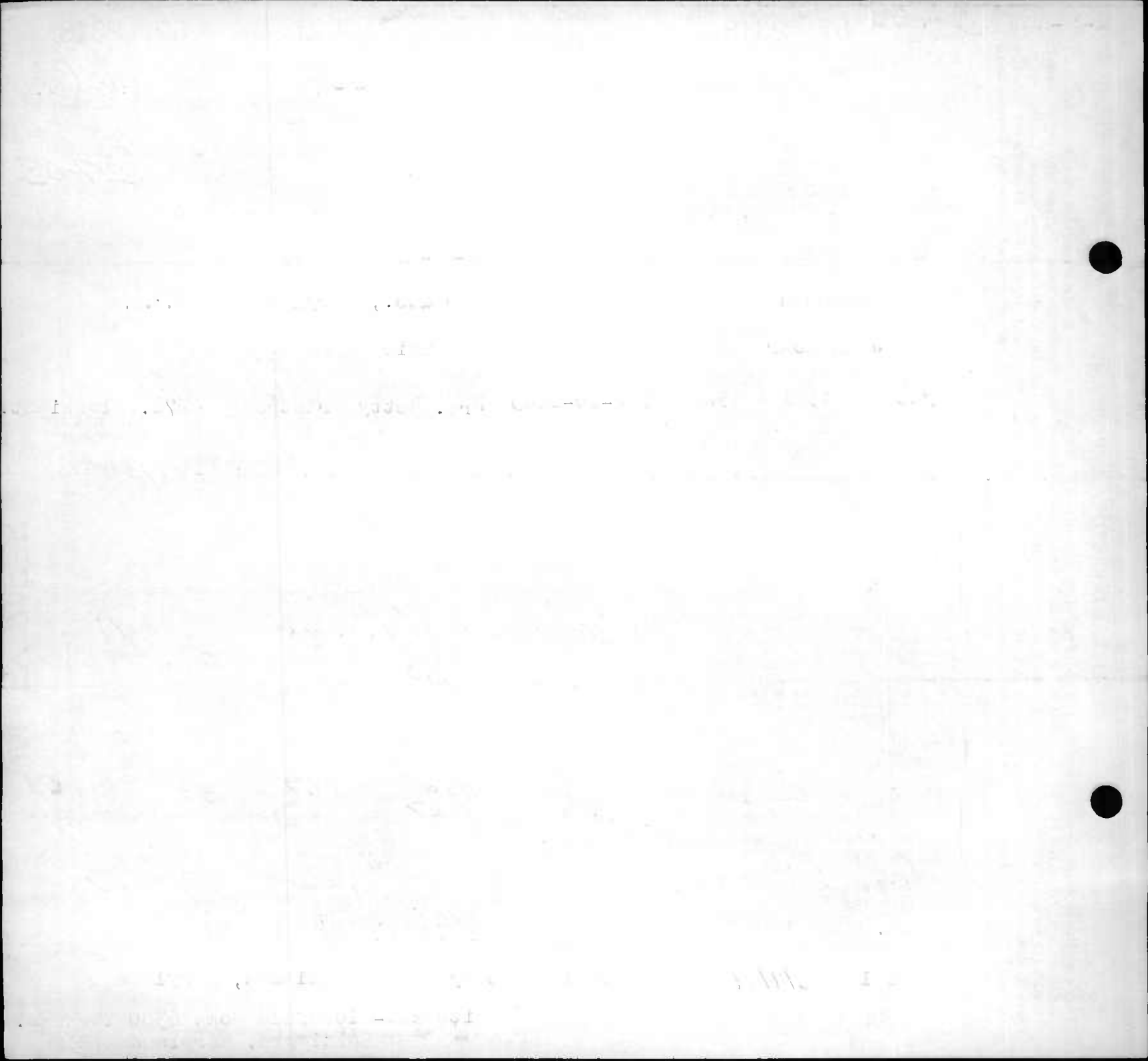
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2318

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

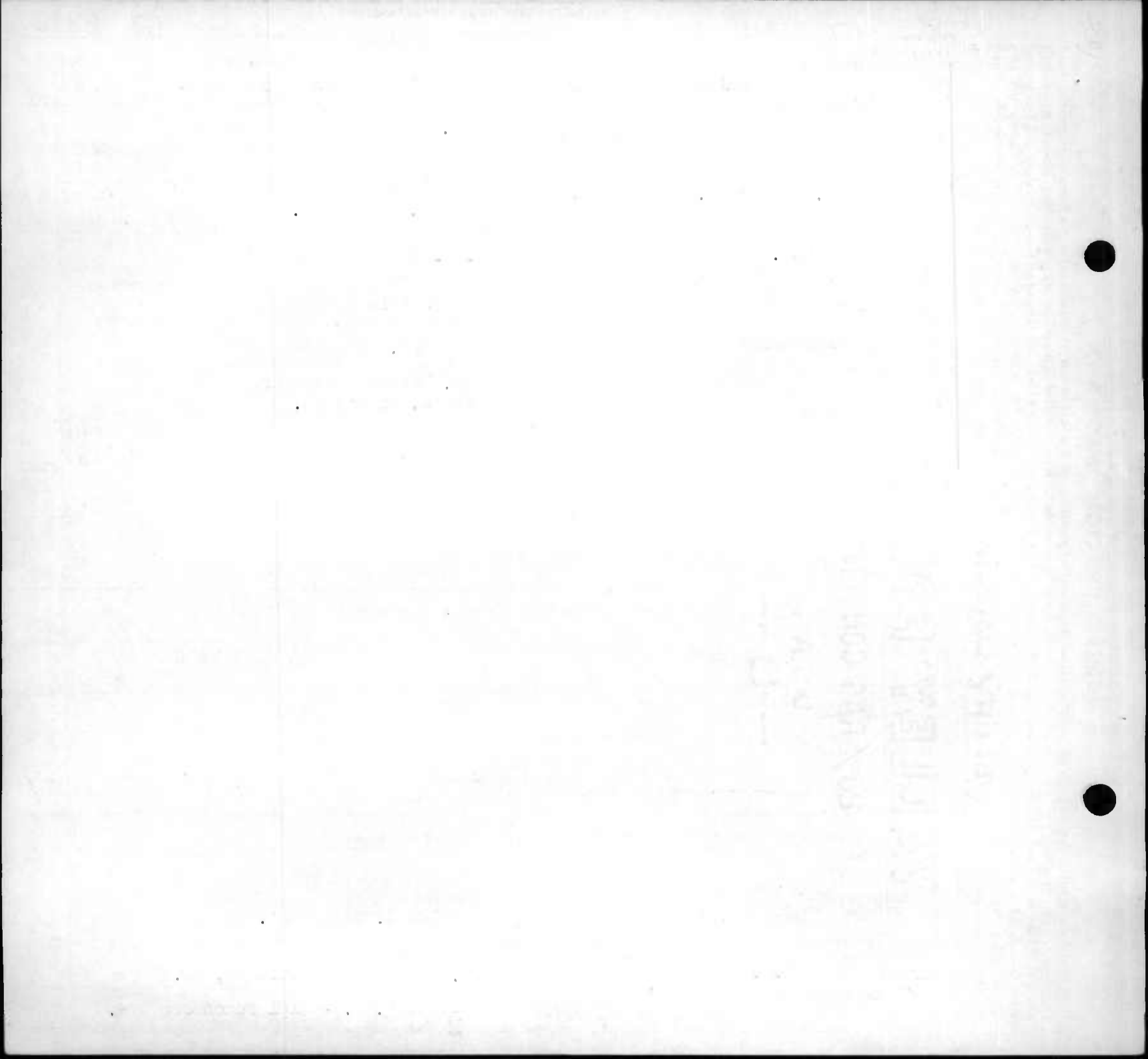
| | | | |
|--|---------------|---|---------------------------|
| BIRTH NO. 67 2318 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) FRANK MOHR | | 2. DATE AND HOUR OF DEATH 3-3-67 6:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2611 STRATHMORE AVENUE 21214 | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 10-10-01 |
| 9. AGE (In years last birthday) 65 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown | |
| 11. BIRTHPLACE (State or foreign country) Balto., Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Mohr | | 14. MOTHER'S MAIDEN NAME Annie SALZMANN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes 1921 & 1922 | | 16. SOCIAL SECURITY NO. 218-10-1185 | |
| 17. INFORMANT BGM: RECORDS 4940 EASTERN AVENUE Mrs. Betty Armstrong 427 S. Pulaski St. | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO chronic lung disease | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | (B) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | |
| 19A. DATE OF OPERATION 3/27/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED carcinoma of larynx | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 1 yr. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/28 19 67 to 3/3 19 67, that (I) (we) last saw the deceased alive on 3/3 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Dr. David Swimmer | | 23B. DATE SIGNED 3/3/67 | |
| 23C. PHYSICIAN'S NAME (Type) DR. DAVID SWIMMER | | 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/7/67 | |
| 24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 25B. NAME OF REGISTRAR Robert E. Fisher | |
| 25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home | | ADDRESS 6500 York Rd. Baltimore, Maryland 21212 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--|--|--|--|--|
| BIRTH NO. 67 2319 | | CERTIFICATE OF DEATH | | 67 2319 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Suzanna Holzinger | | | |
| 2. DATE AND HOUR OF DEATH | | March 5 1967 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Md. | | | |
| Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| D. STREET ADDRESS (If rural, give location) | | Baltimore | | | |
| 400 S. Gilmor St. | | D. STREET ADDRESS (If rural, give location) | | | |
| 400 S. Gilmor St. | | E. AGE (In years last birthday) 86 | | | |
| 5. SEX F | | 6. RACE Cauc. | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | |
| 8. DATE OF BIRTH 9-18-80 | | 9. AGE (In years last birthday) 86 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 11. BIRTHPLACE (State or foreign country) Austria | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Nicholas Geier | |
| 14. MOTHER'S MAIDEN NAME Unk. | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mr. Mathew Holzinger | | ADDRESS 400 S. Gilmor St. | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | |
| Cerebral thrombosis | | INTERVAL BETWEEN ONSET AND DEATH 3 days | | 19. ANTECEDENT CAUSES | |
| arteriosclerotic cerebrovascular disease | | 6 mo | | 20. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | |
| Old age | | — | | 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |
| Divericulous coli | | years | | 22. I certify that (I) (this hospital) attended the deceased from 1967 to 3/5 1967, and that (I) (we) lost saw the deceased alive on 3/5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | |
| 23A. SIGNATURE | | 23B. DATE SIGNED 3/6/67 | | 23C. PHYSICIAN'S NAME (Type) George Vash | |
| 23D. ADDRESS 206 S. Gilmor St. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-9-67 | |
| 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem. | | 24D. LOCATION (City, town, or county) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | |
| 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Witzke F. D. | | ADDRESS 4101 Edmondson Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|--|--|------------------------------------|--|--|---|--|--|
| BIRTH NO. 67 2320 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 67 2320 | | | | |
| 1. NAME OF DECEASED (Type or Print) MR. DAVID E. CULLOP | | | | | 2. DATE AND HOUR OF DEATH 3-8-67 8⁰⁰ P. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CO. | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSPITAL | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 920 LANCE AVE. | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | | 8. DATE OF BIRTH 9-28-88 | 9. AGE (In years lost birthday) 18 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Late ADAM | | | | | 14. MOTHER'S MAIDEN NAME Late MARGARET | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. 227-46-5245 | | 17. INFORMANT GUY CULLOP 920 LANCE AVE (21) | | |
| 18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 wk | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Artery Thrombosis | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2-20-67 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACHEOTOMY | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from 2-9-67 19 67 to 3-8 19 67 , that (I) last saw the deceased alive on 3-8 19 67 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE William T. Mason M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | | | | 23B. DATE SIGNED 3-8-67 | |
| 23C. PHYSICIAN'S NAME (Type) William T. MASON M.D. | | | | | | | | 23D. ADDRESS MERCY HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | 24B. DATE 3/11/67 | | | 24C. NAME OF CEMETERY or CREMATORY BLUE SPRINGS | | | 24D. LOCATION (City, town, or county) (State) SMITH COUNTY, VIRGINIA |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | | 25B. NAME OF REGISTRAR R. E. FARR | | | 25C. FUNERAL DIRECTOR ADDRESS WILKIE 84101 EDMONDSON AVE | | | |

95-05-2

8-4

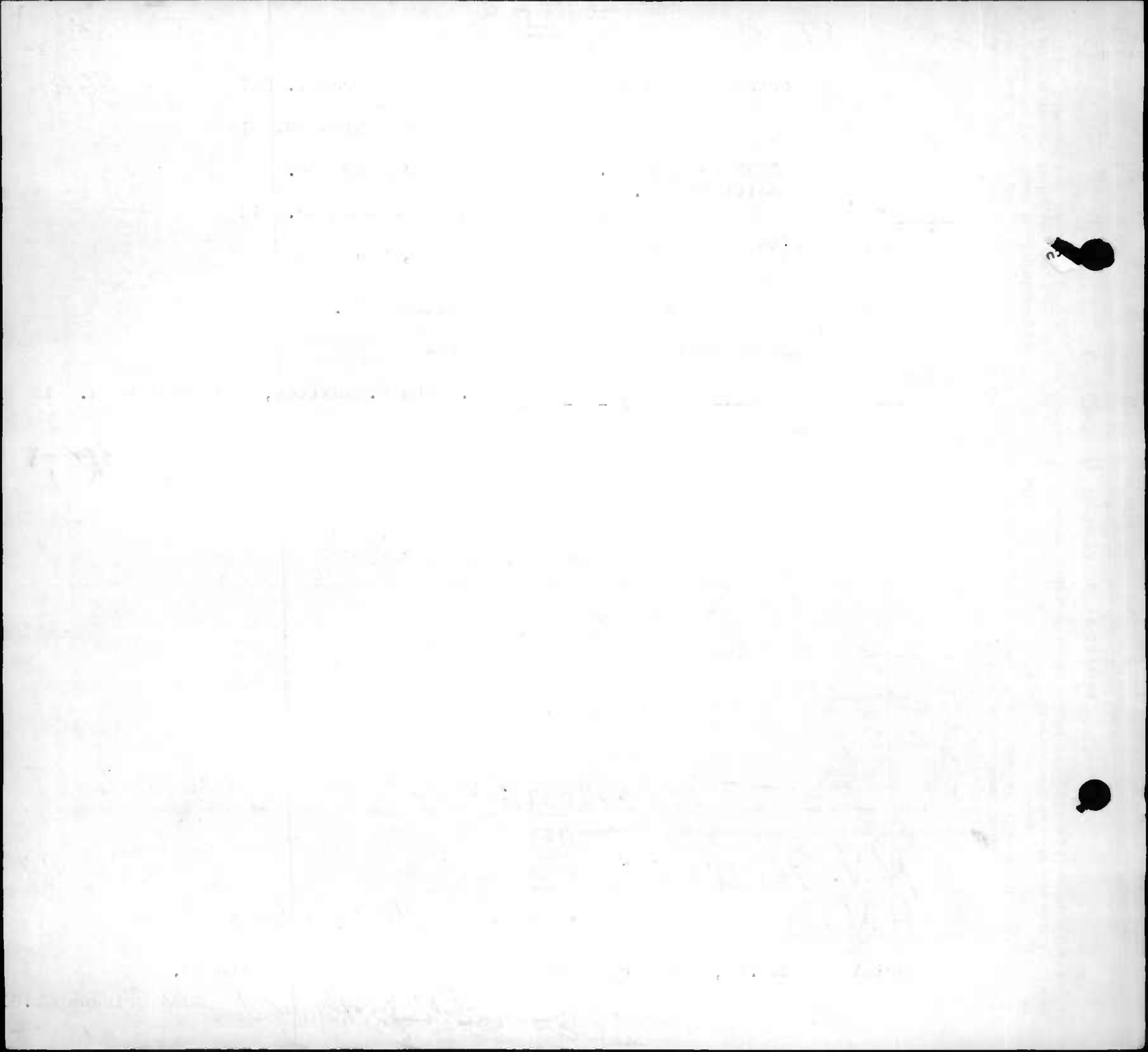
1020M - T max, W
1020AM - T min, W

DATE: 9/20/11 YJN/AM

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2321 | |
|---|---------|--|------------------|--|-----------------------------|
| BIRTH NO. 67 2321 | | CERTIFICATE OF DEATH | | Registered No. 67 2321 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Bertha C. Radwitch | | March 7. 1967 8:40 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| (If not in hospital or institution, give street address or location) | | 5538 Lothian Rd. 12 | | | |
| 00 5538 Lothian Rd. Baltimore Md. 21212 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore Md. | |
| | | D. STREET ADDRESS (If rural, give location) | | 5538 Lothian Rd. 12 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOW, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| Female | White | Widow | July 19, 1886 | 80 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| none | | none | | Baltimore Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Adolph Wess | | --- | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| --- | | 214-22-9082 | | Mr. John E. Radwitch, 5538 Lothian Rd. 12 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | Chronic myocarditis | | 15 yrs | |
| ANTECEDENT CAUSES | | DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Interstitial pulmonary fibrosis | | | |
| | | Subendocardial infarction | | | |
| II | | Multiple gastric ulcers | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 8, 1966 to March 7, 1967. that (I) (we) last saw the deceased alive on March 5, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| H. V. Harbold | | | | March 8, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| H. V. HARBOLD | | 4706 Harford Road Baltimore Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | Mar. 10, 1967 | | Druid Ridge Cem | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 9 1967 | | Philip Horwig Sons | | 2024 Orleans St. 31 | |



BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES

RUSSELL

2. DATE AND HOUR PRONOUNCED DEAD

3-5-67

10:30 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)33
99 JOHN HOPKINS HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

719 N. Chester Street 21205

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

D

8. DATE OF BIRTH

Oct. 12, 1910

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Seaton

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John L. Russell

14. MOTHER'S MAIDEN NAME

Annie Edwards

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

--

16. SOCIAL
SECURITY NO.

236-03-0839

17. INFORMANT

ADDRESS

Mrs. Cornelia Dykman, 719 N. Chester St. 05

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-6-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Mar. 8, 67

23C. NAME OF CEMETERY OR CREMATORY

Cedar Hill Cem

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md.

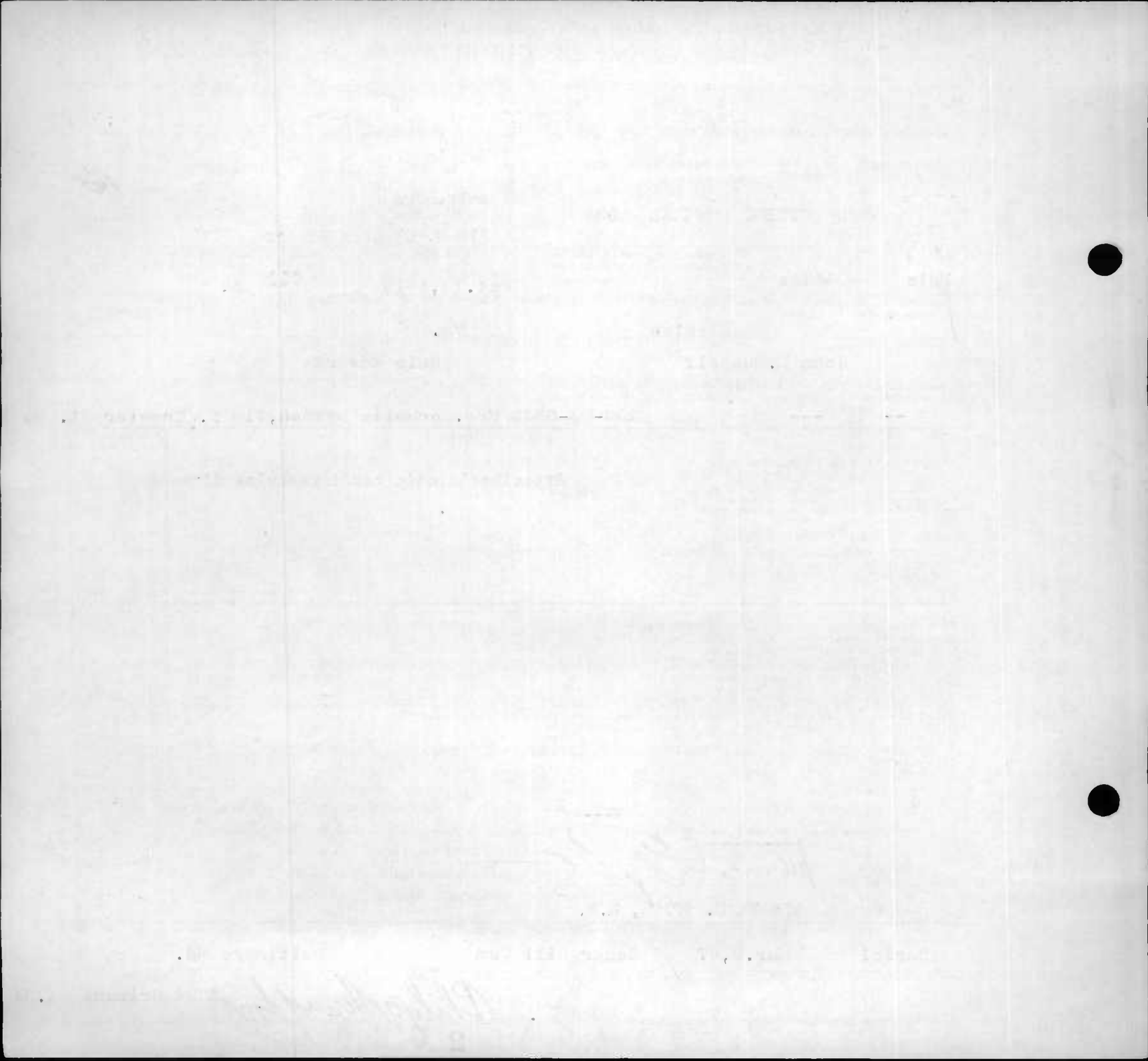
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

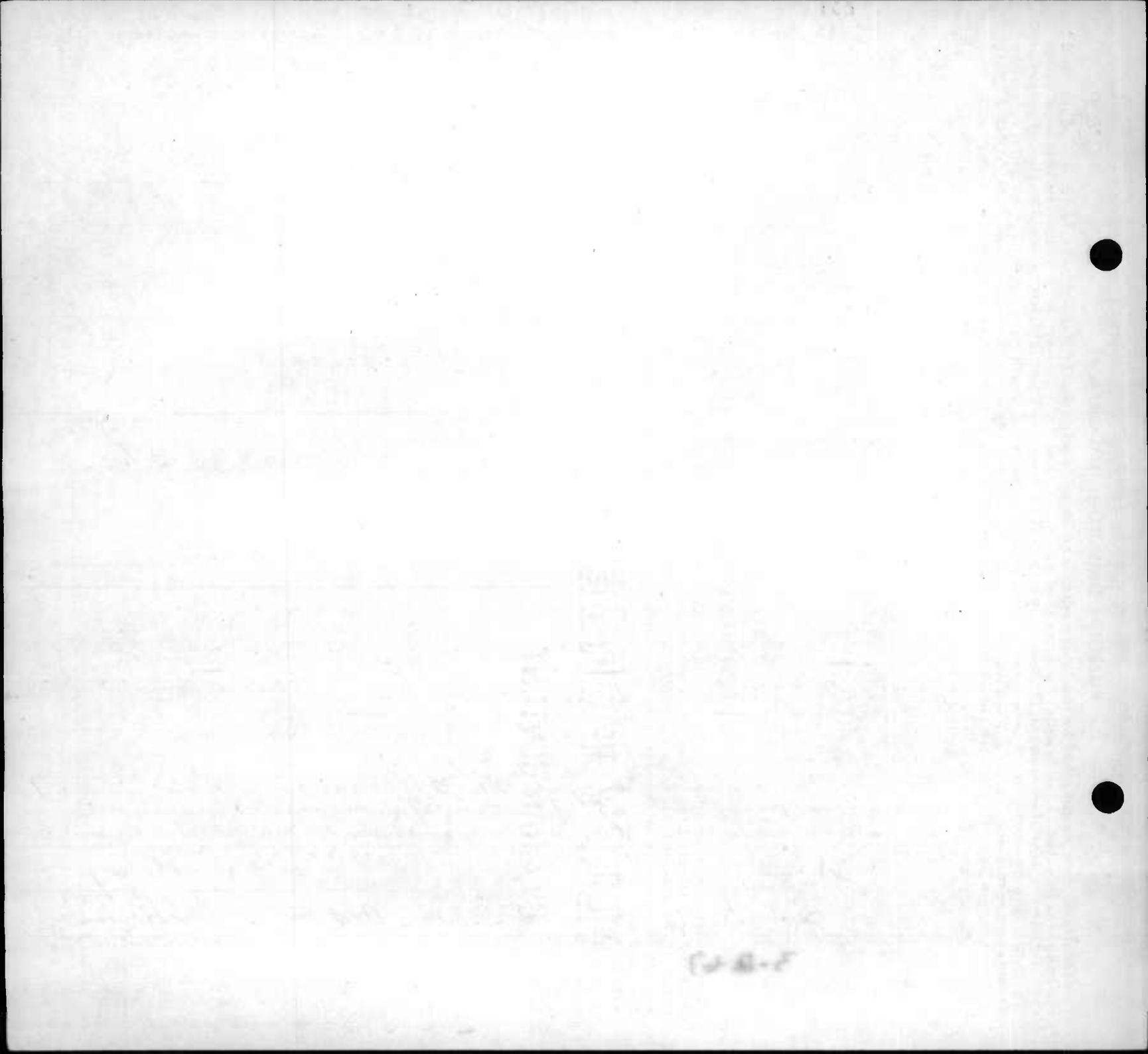
2024 Orleans St. 31



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 2323 | |
|---|---|--|---|---|--|---|---|
| BIRTH NO. 67 2323 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BABY GIRL GREEN | | 2. DATE AND HOUR OF DEATH 2-7-67 @ 12:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL 46 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1111 POPLAR GROVE | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) N/A | 8. DATE OF BIRTH Feb 7th 1967 | 9. AGE (In years lost birthday) N/A | If Under 1 Yr. Months: Days: Hours: Min: 23 | | If Under 24 Hrs. Min: 23 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A | | 10B. KIND OF BUSINESS OR INDUSTRY N/A | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Steven Green | | | | 14. MOTHER'S MAIDEN NAME Gwendolyn Waddell | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N/A | | 16. SOCIAL SECURITY NO. N/A | | 17. INFORMANT ADDRESS | | | |
| 18. 72351 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Prematurity + Respiratory distress | | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 3 hrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (B) DUE TO | | | |
| (C) DUE TO | | | | | | | |
| 19A. DATE OF OPERATION 2/7/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) N/A | | 21E. INJURY OCCURRED While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? N/A | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/7/67 1967 to 12/27/67 1967, that (I) (we) last saw the deceased alive on 2/7/67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (Yes) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE S. Kim | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/7/67 | |
| 23C. PHYSICIAN'S NAME (Type) S. Kim | | | | 23D. ADDRESS M.D. Lutheran Hosp. Int., Baltimore, MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 3-2-67 | | 24B. DATE 3-2-67 | | 24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 25B. NAME OF REGISTRAR R. E. Taylor | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2324 | |
|---|-----------------|--|-------------------------|--|---|
| BIRTH NO. 67 2324 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. 67 2324 | | 1. NAME OF DECEASED (Type or Print) BOY MARTIN | | | |
| 2. DATE AND HOUR OF DEATH 2/4/67 8:20 P. M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSP. OF MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | D. STREET ADDRESS (If rural, give location) DENISON ST. 20-07 | | | |
| 5. SEX MALE | 6. RACE COLORED | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 2/2/67 | 9. AGE (In years last birthday) 2 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME John MARTIN | | 14. MOTHER'S MAIDEN NAME CAROL DAVIS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Prematurity (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/2/67 19 to 2/4/67 19, that (I) (we) last saw the deceased alive on 2/4/67 8:20 P. M. and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE L. J. Kenna | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 2/4/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS LUTHERAN HOSPITAL OF MARYLAND | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 3-2-67 | | 24C. NAME OF CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 - 1967 | | 25B. NAME OF REGISTRAR R. E. J. Kenna | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE | |

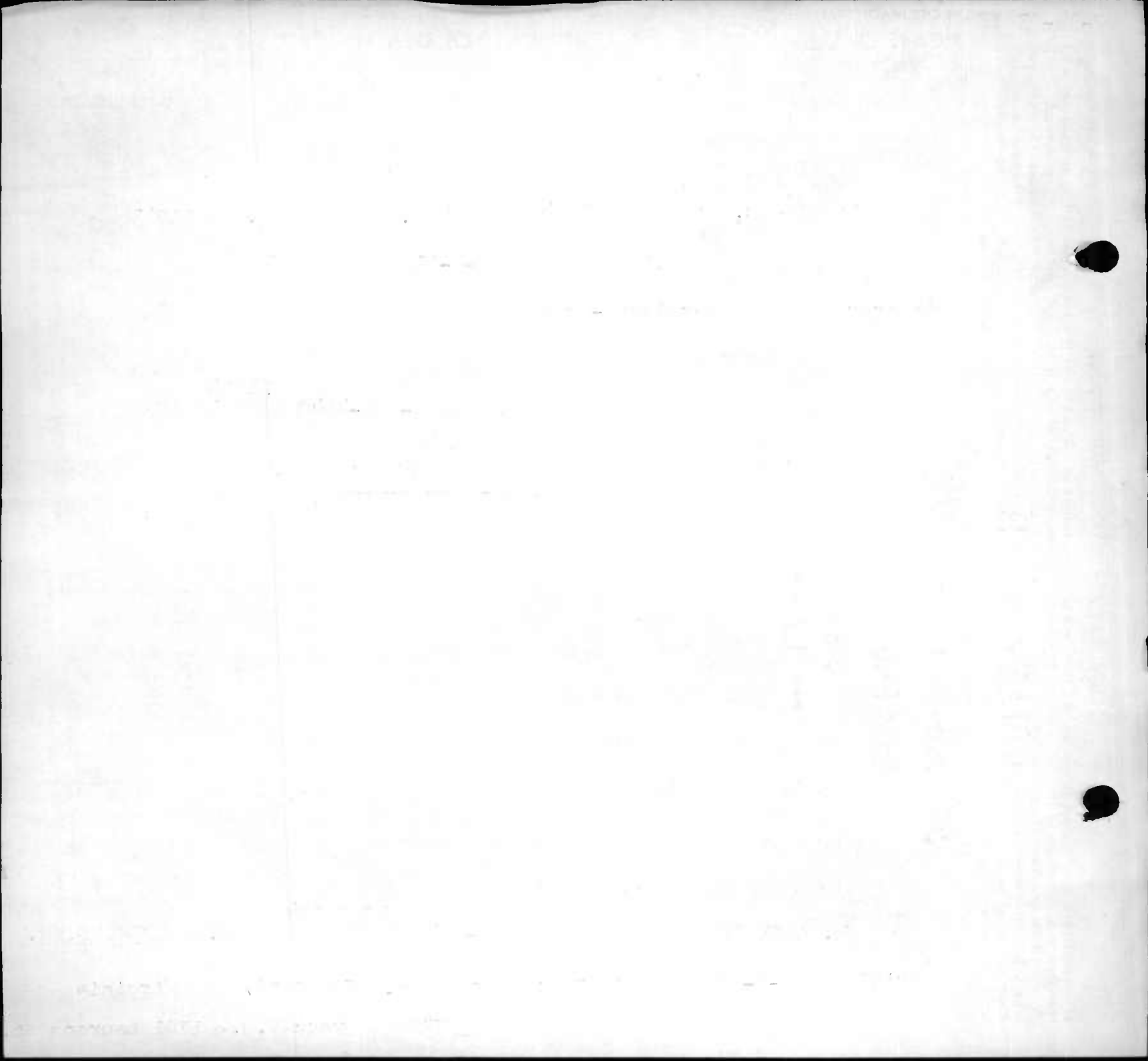
10-5-8

47-34-63 1B

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2325 | |
|---|---------|--|------------------|--|--|
| BIRTH NO. H-52267 2325 | | | | | |
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Ralph Hancock</i> | | | |
| 2. DATE AND HOUR OF DEATH | | 3-5-67 11 ⁰⁰ P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | MARYLAND | | | |
| BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location) | | 2584 W. FAYETTE ST, #21223 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| MALE | NEGRO | MARRIED | 4-2-11 | 55 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Laborer | | Bethlehem-Steel | | VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY? | | USA | | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| JOHN HENRY HANCOCK | | NANNIE HAMLET | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | 21224 RECORDS-BCH-4940 EASTERN AVENUE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 18. <i>Cell Carcinoma of Lung</i> | | 1 1/2 yrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-19 1967 to 3-5 1967, that (I) (we) last saw the deceased alive on 3-5 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| <i>Alex Silverman</i> | | | | 3-5-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| DR. ALEX SILVERMAN | | 21224 BCH-4940 EASTERN AVENUE, BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3-9-67 | | Hat Creek Church Cem, Brookneal, Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 9 1967 | | <i>Robert E. Taylor</i> | | Morton & Dyett F.H., 1701 Laurens St. | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MARGARET A. MACKEY

2. DATE AND HOUR PRONOUNCED DEAD

3-6-67

6:20 PM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3311 Walbrook Avenue - Amb. Crew #8

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3311 Walbrook Avenue 21216

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

5-30-44

9. AGE (In years
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retail Clerk

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CHARLES MACKEY. SR.

14. MOTHER'S MAIDEN NAME

SOPHRONIA GRIFFIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

213-44-9544

17. INFORMANT

ADDRESS

Mrs. Sophronia Mackey 1729 Thomas Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Bronchial and interstitial pneumonia
possibly in association with bronchial
asthma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRI-
BUTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-7-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

2-10-67

23C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

23D. LOCATION

(City, town, or county)

Arbutus,

(State)

Maryland

24A. DATE REC'D BY HEALTH DEPT.

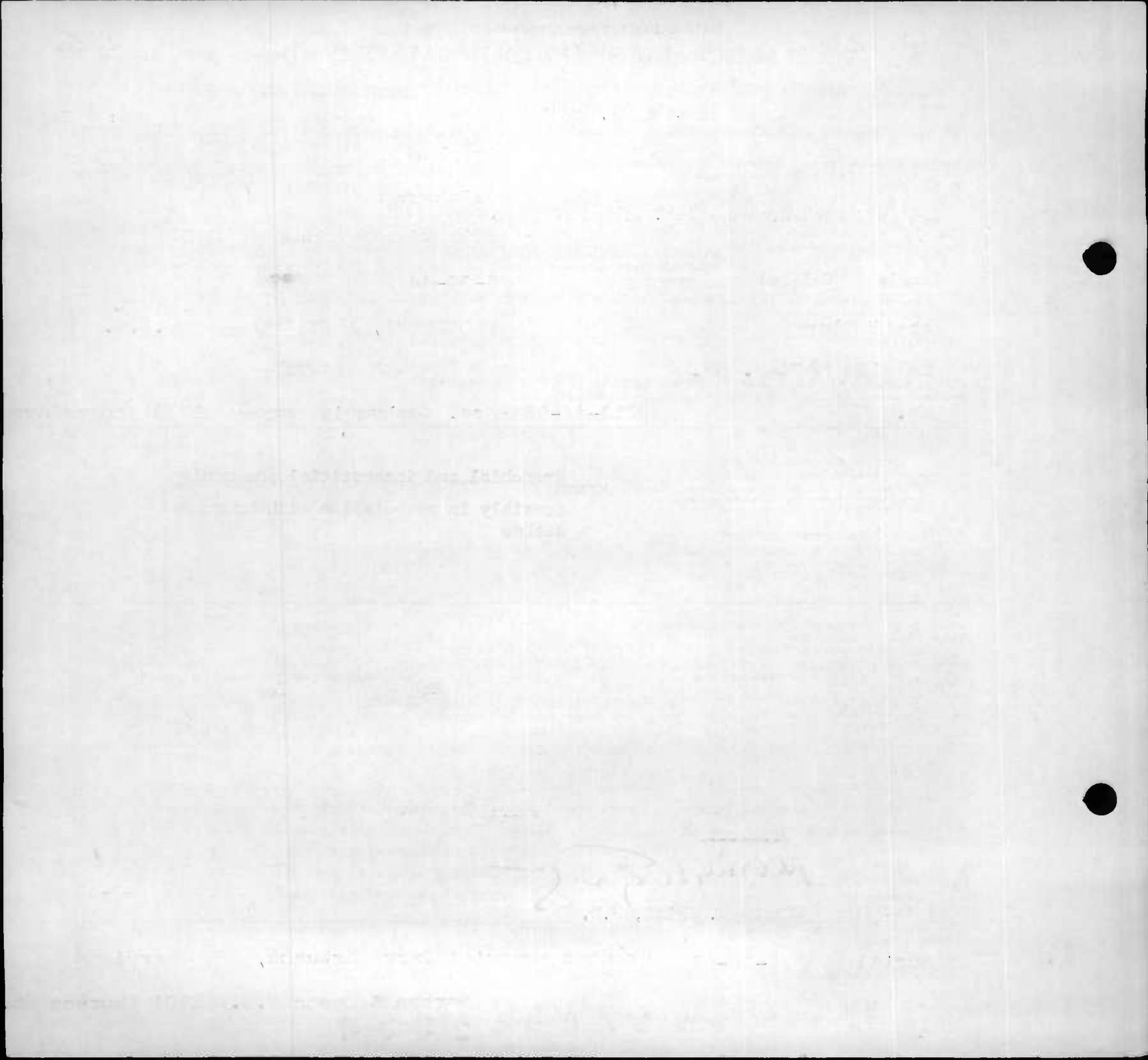
24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 9 1967

Morton & Dyett F.H. 1701 Laurens St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 2327 | |
|---|--|-------------------------|---|--|--|--|--|---|--|--|--|
| BIRTH NO. 67 2327 | | | | | | | | | | BALTIMORE CITY HEALTH DEPARTMENT | |
| M.E. CASE NO. | | | | | | | | | | BALTIMORE CITY HEALTH DEPARTMENT | |
| 1. NAME OF DECEASED (Type or Print) <i>Delly, MR. John H.</i> | | | | | 2. DATE AND HOUR OF DEATH <i>3-8-67 6:50 a.m.</i> | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Bon Secours Hosp.</i> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | D. STREET ADDRESS (If rural, give location) <i>2704 W. Baltimore St.</i> | | | | | | |
| 5. SEX <i>M</i> | | 6. RACE <i>NEGRO</i> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i> | | 8. DATE OF BIRTH <i>2-27-06</i> | | 9. AGE (In years last birthday) <i>61</i> | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welder Helper</i> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Beth. Steel</i> | | 11. BIRTHPLACE (State or foreign country) <i>So. Carolina</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Delly, BROOKIN</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Brice, Lottie</i> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. <i>213-09-1727</i> | | 17. INFORMANT <i>Mrs. Uola Delly</i> | | | ADDRESS <i>2704 W. Baltimore St.</i> | |
| 18. <i>#43X1</i> | | | | | CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) <i>Hypertensive and arteriosclerotic heart disease</i> | | | | | <i>years</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO | | | | | | |
| (C) DUE TO | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY (Yes or No) <i>Yes</i> | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? | | | (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that <i>HT</i> (this hospital) attended the deceased from <i>MAR 1</i> 19 <i>67</i> to <i>MAR 8</i> 19 <i>67</i> , that <i>HT</i> (we) last saw the deceased alive on <i>MARCH 8</i> 19 <i>67</i> and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>HT</i> (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED <i>3/8/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>SPMD BRATHAM</i> | | | | | 23D. ADDRESS M.D. <i>Bon Secours Hospital</i> | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | 24B. DATE <i>3-11-67</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>H. Calvary Cemetery</i> | | | 24D. LOCATION (City, town, or county) (State) <i>A.A.Co. MD.</i> | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. <i>MAR 9 1967</i> | | | 25B. NAME OF REGISTRAR <i>[Signature]</i> | | | 25C. FUNERAL DIRECTOR <i>Hoefinger, Dyer F.H.</i> | | | ADDRESS <i>1701 Laurens St.</i> | | |

Ben Seaver Hospital

3/18/52

MARCH 8

MARCH 1

CS

MAR 2

YES

YES

Psychomotor and autonomic
heart disease

Specimen

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | |
|--|---|--|---|
| <div style="display: flex; justify-content: space-between;"> K-430 67 2328 U.S. CITY AND COUNTY DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> | | Registered No. 67 2328 | |
| BIRTH NO. 67 2328 M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 3-7-67 8³⁰ P.M. | |
| 1. NAME OF DECEASED (Type or Print) KLUTH, ANNA E. | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY A. A. Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glen Burnie D. STREET ADDRESS (If rural, give location) 500 Old Annapolis Boulevard | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University of Maryland Hospital Greene + Lombard Sts, Balto | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 6-13-85 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 81 |
| 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John H. Riley | | 14. MOTHER'S MAIDEN NAME Kath Stumpf | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-30-1221 A | 17. INFORMANT Chart |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Acute myocardial infarction DUE TO (B) ASCVD DUE TO (C) _____ | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH 20 days 35 yrs | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22. I certify that (this hospital) attended the deceased from 2-15 19 67 to 3-7 19 67 . that (we) last saw the deceased alive on 3-7 19 67 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE David F. Zickafoose | | 23B. DATE SIGNED 3/7/67 | |
| 23C. PHYSICIAN'S NAME (Type) David F. Zickafoose | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3/11/1967 | 24C. NAME OF CEMETERY OR CREMATORY Western Cemetery | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 25B. NAME OF REGISTRAR Robert E. Johnson | |
| 25C. FUNERAL DIRECTOR Wm. F. Johnson | | 25D. ADDRESS Baltimore, Md. 21201 | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2329 | |
|--|---------------------------|---|---|---|--|
| BIRTH NO. 67-03461 2329 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Baby Girl Simmons | | | | 2. DATE AND HOUR OF DEATH Feb 20th 1967 11 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 LUTHERAN HOSPITAL of MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 13-48 D. STREET ADDRESS (If rural, give location) 2214 Roslyn Ave. | |
| 5. SEX F | 6. RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH Feb 19th 1967 | | 9. AGE (In years last birthday) 17 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Lutheran Hospital of Md | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME BUELAH SIMMONS | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 762.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Prematurity + Apnea DUE TO (B) _____ DUE TO (C) _____ | |
| | | | | INTERVAL BETWEEN ONSET AND DEATH 5 hours | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 19th 1967 to Feb 20th 1967 , that (I) (we) last saw the deceased alive on Feb 19th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Nguyen Thi Oanh | | | | 23B. DATE SIGNED 2/20/67 | |
| 23C. PHYSICIAN'S NAME (Type) NGUYEN THI OANH | | | | 23D. ADDRESS Lutheran Hospital of Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 3-2-67 | | 24C. NAME OF CEMETERY or CREMATORY | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | |

Page 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------|--|--|--|---------------------------------------|
| 67 03896 67 2330 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 67 2330 4 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Baby Girl Joyner</i> | |
| 2. DATE AND HOUR OF DEATH 2-25-67 @ 5:15 pm M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>of md Lutheran Hospital 46 730 Ashburton St #16</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE # 21216 16-07</i> D. STREET ADDRESS (If rural, give location) <i>1602 N. Hilton St</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>C</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 2-25-67 | 9. AGE (In years last birthday) 15 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>ERIC LEON JOYNER</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>VIRGINIA ELIZABETH JACKSON</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | |
| 16. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>726X I Remarking</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>15 hrs.</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>no</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3:00 pm, 2/25</i> 19 <i>67</i> to <i>5:15 pm, 2/25</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>2/25</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>SK</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>2/27/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Shingill KIM</i> | | 23D. ADDRESS <i>University Medical School, Baltimore</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>3-2-67</i> | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY <i>UNIVERSITY MEDICAL SCHOOL</i> | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 9 1967</i> | | | |
| 25B. NAME OF REGISTRAR <i>2/25/67</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>MORTUARY SERVICE - BCHO</i> | | | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|----------------------|---|-----------------------------------|--|---|
| BIRTH NO. 67 2331 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2331 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>TURNER, Georgia</i> | | 2. DATE AND HOUR OF DEATH <i>3/6/67 10 40 P. M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>15-12</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>John Cohn Memorial Nursing Home</i> <i>27 N. Carey Street</i> <i>Baltimore, Maryland 21223</i> | | D. STREET ADDRESS (If rural, give location) <i>2908 Violet Ave.</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>6/25/1907</i> | 9. AGE (In years last birthday) <i>59</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | |
| 13. FATHER'S NAME <i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Janie Williams 16" N. Walf St</i> | |
| 18. <i>1810 I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of Stomach</i> | | (A) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2/23 1967</i> to <i>3/6 1967</i> , that (I) (we) last saw the deceased alive on <i>3/6 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>John Sennarone M.D.</i> | | | | 23B. DATE SIGNED <i>3/6/66</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>John Sennarone</i> | | | | 23D. ADDRESS <i>930 Whitelock St. Balt. Md.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3/11/67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>W. Auburn</i> | |
| 24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i> | | 24E. NAME OF REGISTRAR <i>Charles A. Rice</i> | | 24F. FUNERAL DIRECTOR ADDRESS <i>661 W. Carey St.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 9 1967</i> | | 25B. NAME OF REGISTRAR <i>Charles A. Rice</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>661 W. Carey St.</i> | |

22 June 1912
Mrs. Jones

B. 235

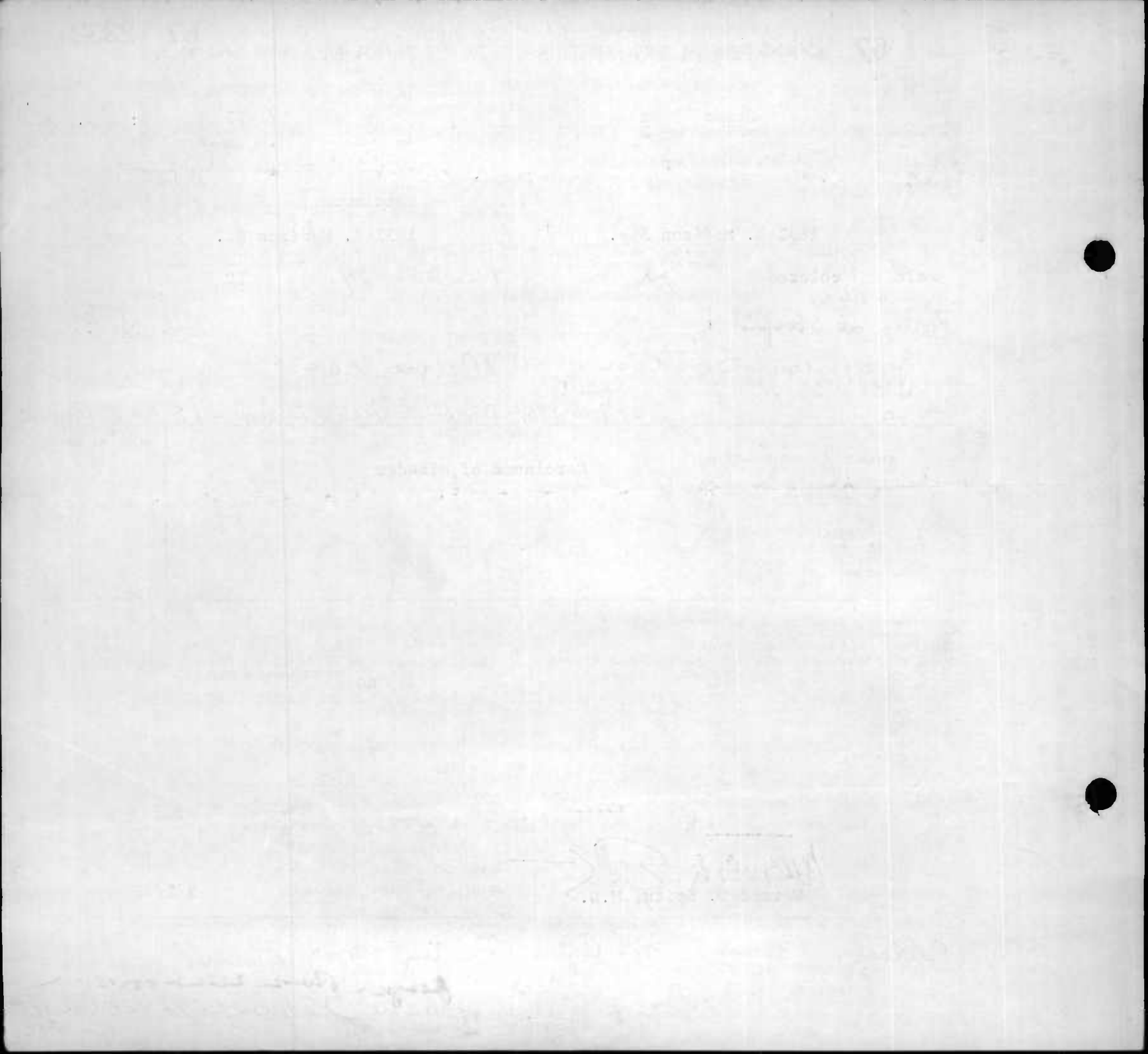
BALTIMORE CITY HEALTH DEPARTMENT

67 2332

BIRTH NO. 67 2332 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2332

M.E. CASE NO.

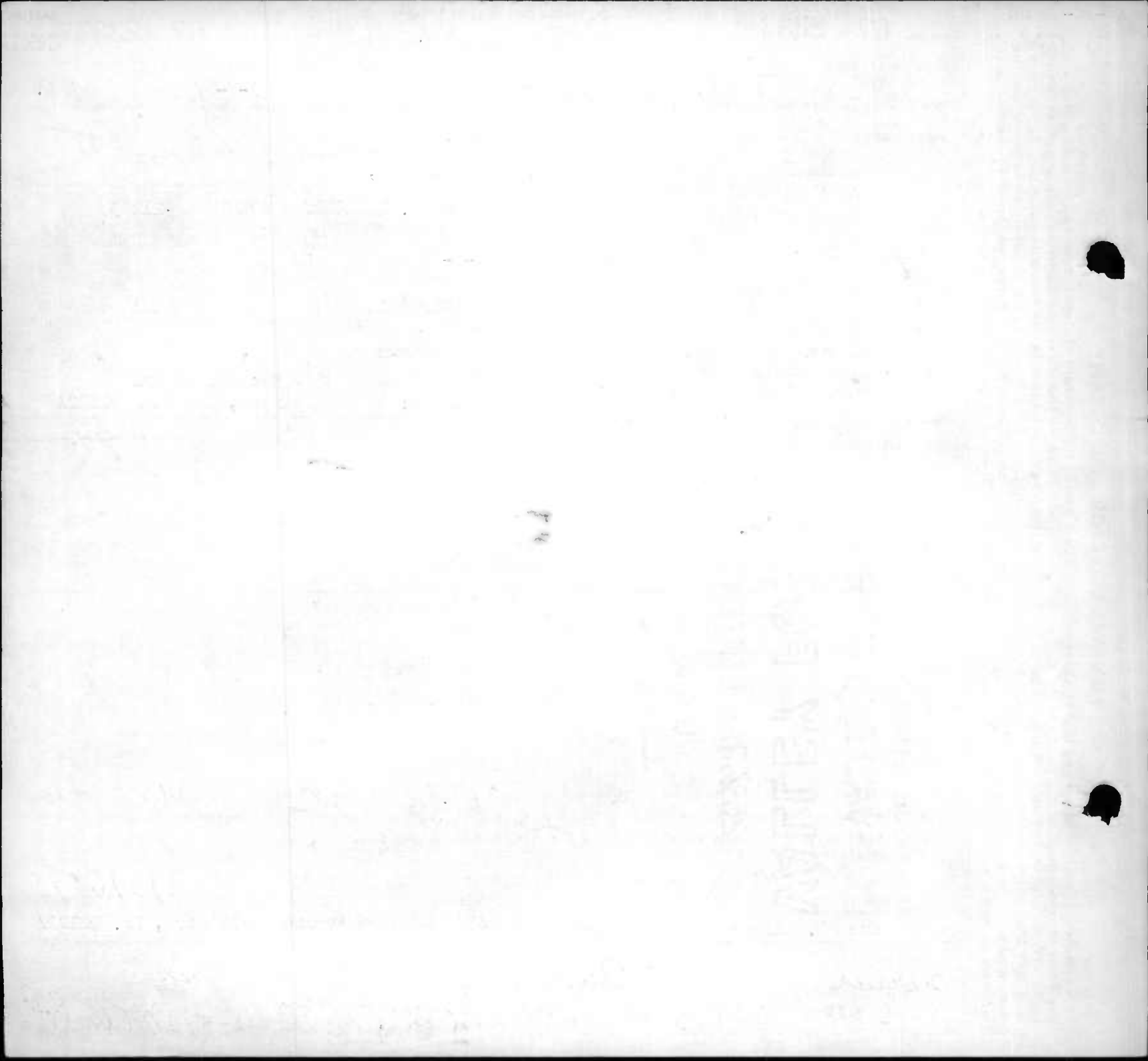
| | | | | | | | |
|---|---------------------------|---|---------------------------------------|---|---|--|--|
| 1. NAME OF DECEASED (Type or Print) James Boston | | | | 2. DATE AND HOUR PRONOUNCED DEAD 3/1/67 8:00 p. m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 00 1832 E. Madison Ave. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 7-05 D. STREET ADDRESS (If rural, give location) 1832 E. Madison St. | | | |
| 5. SEX male | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 12-25-1894 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter at Hospital | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME James Boston | | | | 14. MOTHER'S MAIDEN NAME Marie Ross | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 219.16-9959 | | 17. INFORMANT Mrs Rebecca Boston - 1832 E. Madison | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of bladder ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/2/67 ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 3-6-67 | | 23C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery | | 23D. LOCATION (City, town, or county) (State) Mt. Winas | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 24B. NAME OF REGISTRAR Robert E. Spitz | | 24C. FUNERAL DIRECTOR Barrie V. Cooper | | ADDRESS 2222 N. Carroll Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

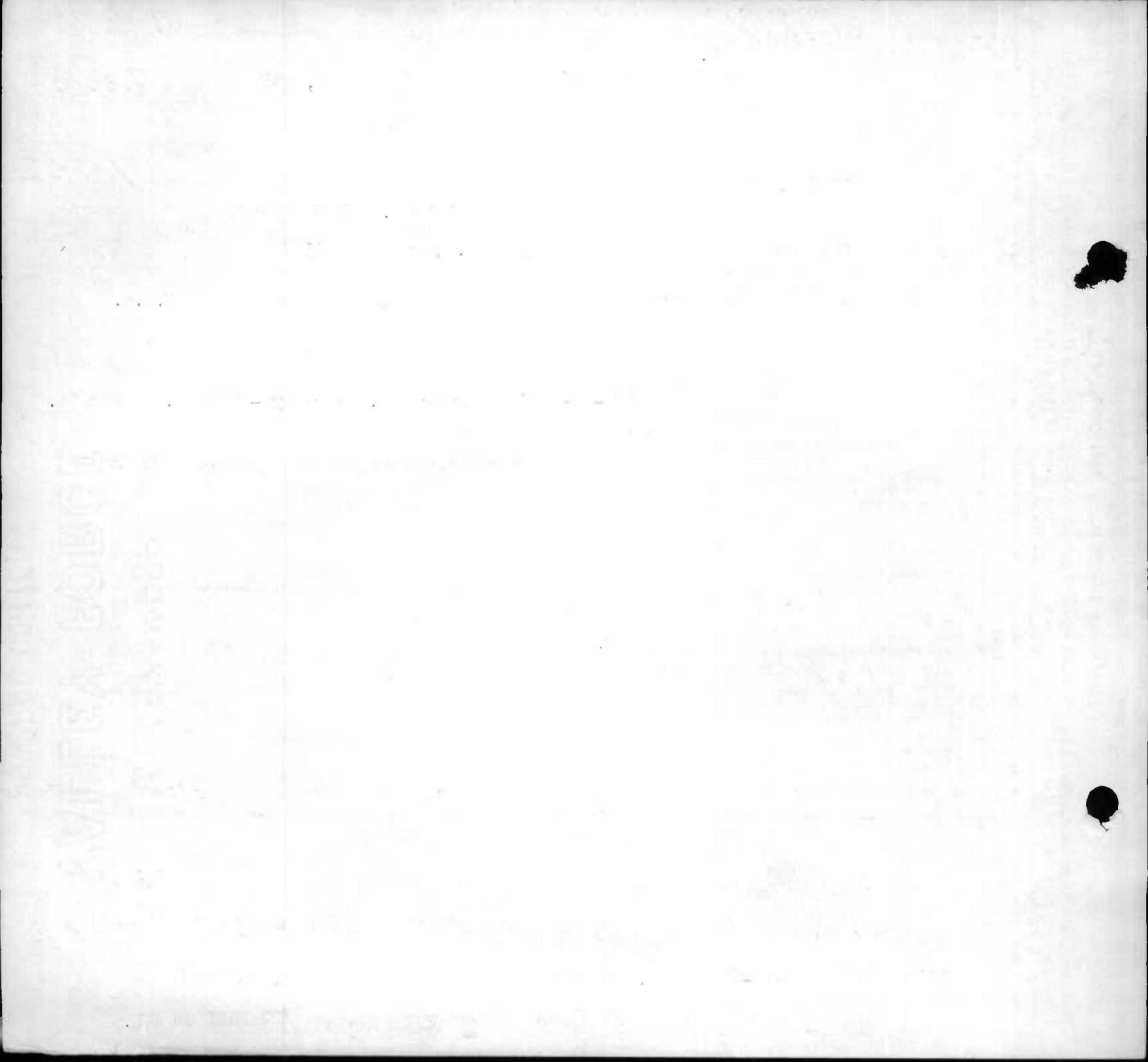
| 48-64-88 DH 1 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2333 | |
|--|------------------|--|----------------------------|---|---|
| BIRTH NO. 67 2333 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Braxton Taylor</u> Braxton Taylor | | 2. DATE AND HOUR OF DEATH 3-3-67 8 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 18-02 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, | |
| FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND #21224 | | D. STREET ADDRESS (If rural, give location) 508 N. CARROLLTON AVENUE #21223 | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH 9-3-78 | 9. AGE (In years last birthday) 88 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT BCH 4940 Eastern Avenue RECORDS: Baltimore, Maryland #21224 | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) 77 years DUE TO (B) aspiration pneumonia DUE TO (C) P.C.V.A. | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | P/O Marked wasting primary carcinoma metastases | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/5/67 19 67 to 3/3 19 67, that (I) (we) last saw the deceased alive on 3/3 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A. L. Silver | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/3/67 | |
| 23C. PHYSICIAN'S NAME (Type) Ann L. Silver | | 23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Md. #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cent. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 24E. FUNERAL DIRECTOR Joseph P. Cooper-5127 Carrollton | | 24F. ADDRESS as above | |
| 25A. DATE REC'D BY HEALTH DEPT. 3-8-MAR 9 1967 | | 25B. NAME OF REGISTRAR Robert E. [unclear] | | 25C. FUNERAL DIRECTOR Joseph P. Cooper-5127 Carrollton | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

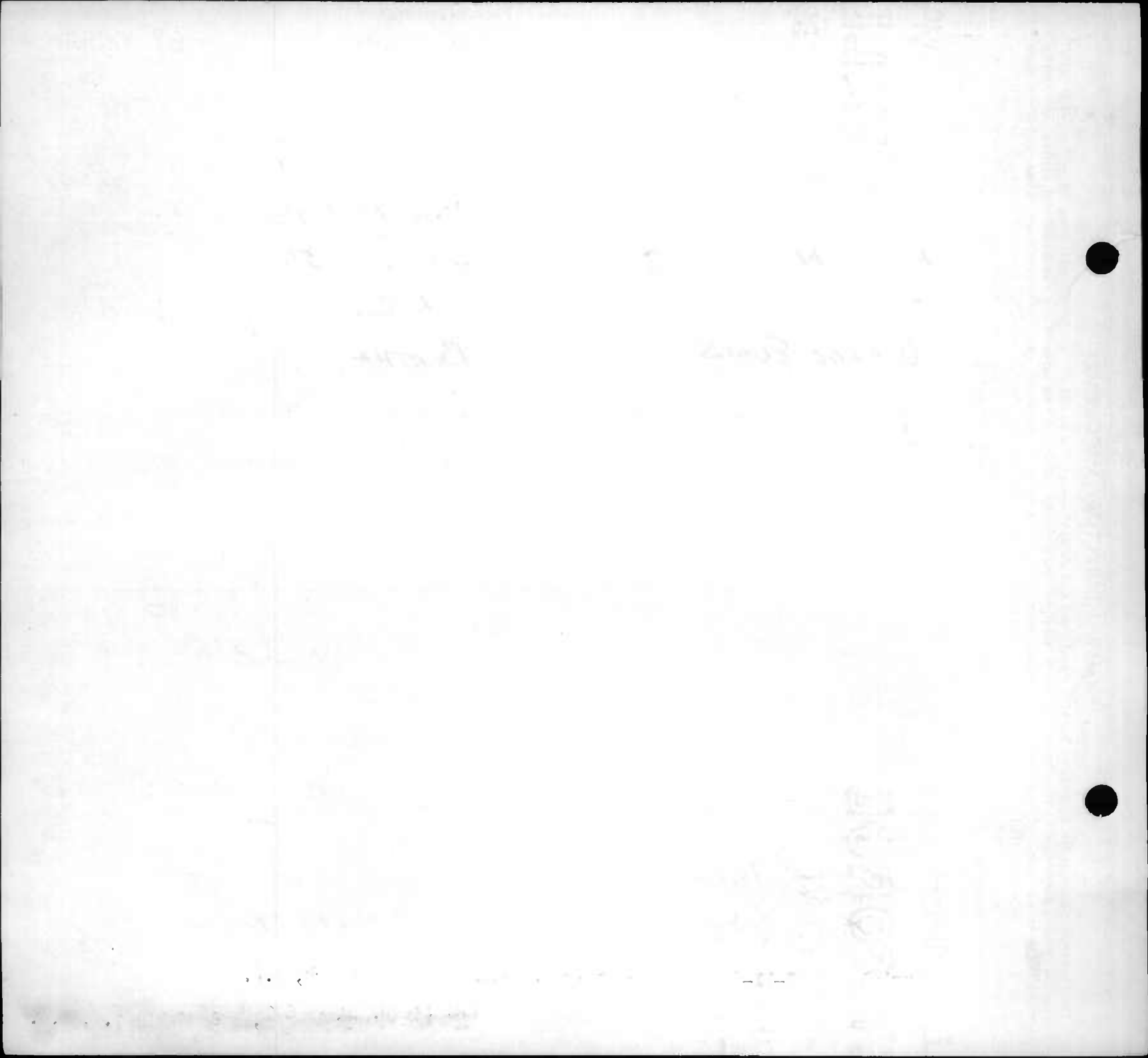
| | | | | | |
|--|--------------------|--|----------------------------------|--|---|
| BIRTH NO. 67 2334 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2334 | |
| M.E. CASE NO. | | M. | | | |
| 1. NAME OF DECEASED (Type or Print) | | ALEASE WEST (GRANT) | | 2. DATE AND HOUR OF DEATH MARCH 8, 1967 8:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1716 N. PAYSON STREET | | A. STATE MARYLAND B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 1716 N. PAYSON STREET | | | |
| 5. SEX FEMALE | 6. RACE COLORED | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH NOV. 2, 1921 | 9. AGE (In years lost, birthday) 45 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TECHNICIAN | | 10B. KIND OF BUSINESS OR INDUSTRY ART | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JAMES SANDERS | | 14. MOTHER'S MAIDEN NAME WILLIE MAUD SMITH | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 218-18-4034 | | 17. INFORMANT Margaret S. Courtney - 1716 N. Payson St. | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO Metastatic Carcinoma of Lung | | 6 mos. | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 12/1/66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinomatous | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/4 1966 to 3/8 1967, that (I) (we) last saw the deceased alive on 3/6/67 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert J. Himelfarb | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/8/67 | |
| 23C. PHYSICIAN'S NAME (Type) Albert J. Himelfarb | | 23D. ADDRESS 3501 ST. PAUL ST. BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-12-67 | | 24C. NAME OF CEMETERY or CREMATORY MT. CALVARY | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | | |
| 25B. NAME OF REGISTRAR Charles R. Law | | 25C. FUNERAL DIRECTOR CHARLES R. LAW | | | |
| 25D. ADDRESS 802 MADISON AVE. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---|---|---|--|--|--|--|---|---------|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2335 | | | | |
| BIRTH NO. 67 2335 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) Edmond Evans | | | | | 2. DATE AND HOUR OF DEATH March 7, 1967 1²⁰ P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALT. CITY | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) " " #17 11-04 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 1210 McCulloch ST. | | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S | 8. DATE OF BIRTH 5-19-09 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY Machinist | | 11. BIRTHPLACE (State or foreign country) N.C. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WALDOO EVANS | | | | | 14. MOTHER'S MAIDEN NAME BERTHA KING | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 244-12-6473 | | 17. INFORMANT Rosa Beaton, 1210 McCulloch ST. | | | | ADDRESS |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Nephrosclerosis with Renal Failure | | | | | INTERVAL BETWEEN ONSET AND DEATH approx. 2-3 mos. | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO Malignant Hypertension approx 2-3 yrs. | | | | |
| | | | | | (B) DUE TO | | | | |
| | | | | | (C) DUE TO | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Lytic Arthritis | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 14 1967 to March 7 1967, that (I) (we) last saw the deceased alive on March 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE R.H. Anderson | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 3/7/67 | |
| 23C. PHYSICIAN'S NAME (Type) R.H. Anderson | | | | | 23D. ADDRESS M.D. University Hospital, Baltimore Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-11-67 | | 24C. NAME OF CEMETERY OR CREMATORY Woodland Cemetery | | | 24D. LOCATION (City, town, or county) (State) Newark, N.J. | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 25B. NAME OF REGISTRAR Charles R. Law | | | 25C. FUNERAL DIRECTOR ADDRESS 802 MADISON AVENUE BALTIMORE, MARYLAND | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|---------------------------|--|---|--|---|
| BIRTH NO. 67 2336 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2336 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) MILDRED McCASKILL | | | 2. DATE AND HOUR OF DEATH MARCH 6, 1967 4⁰⁵ pm M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1835 DRUID HILL AVENUE | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1835 DRUID HILL AVE. | | |
| 5. SEX FEMALE | 6. RACE COLORED | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH MAY 4, 1895 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | |
| 13. FATHER'S NAME PETER SAMUELS | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 085-05-1200 | | 17. INFORMANT CATHERINE BOWMAN # 1835 DRUID HILL AVE. |
| 18. 154X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARCINOID, GENERALIZED ANTECEDENT CAUSES (B) CARCINOID OF RECTUM DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 4 y cars unknown |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from January 16 19 64 to MARCH 6 19 67 , that (I) (we) last saw the deceased alive on FEB 22 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Richard D. Hahn | | | | 23B. DATE SIGNED 3/8/67 | |
| 23C. PHYSICIAN'S NAME (Type) RICHARD D HAHN | | | | 23D. ADDRESS 1010 SAINT PAUL ST. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-9-67 | | 24C. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | | |
| 25B. NAME OF REGISTRAR Charles R. Law | | 25C. FUNERAL DIRECTOR ADDRESS CHARLES R. LAW 802 MADISON AVE. | | | |

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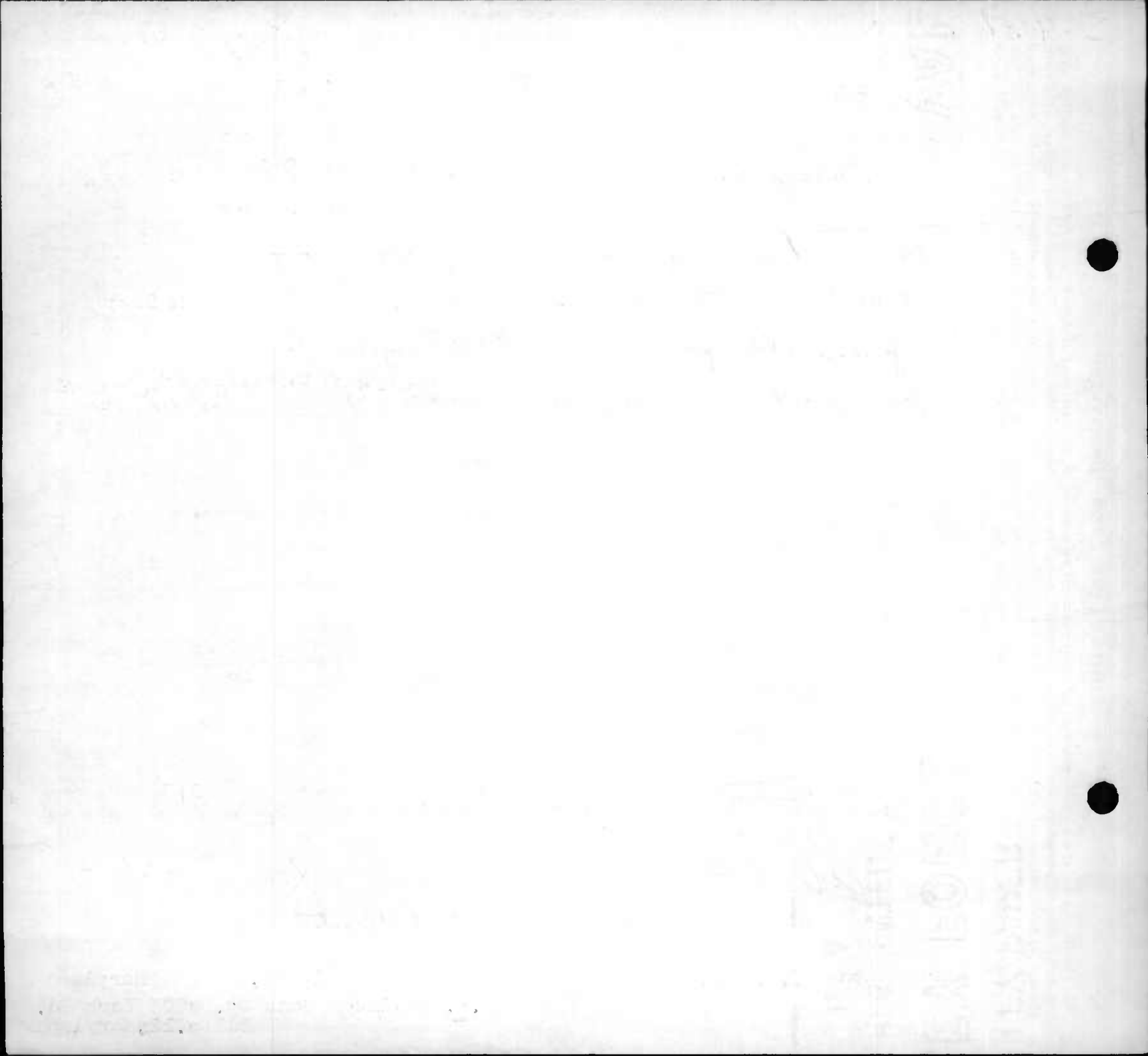
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

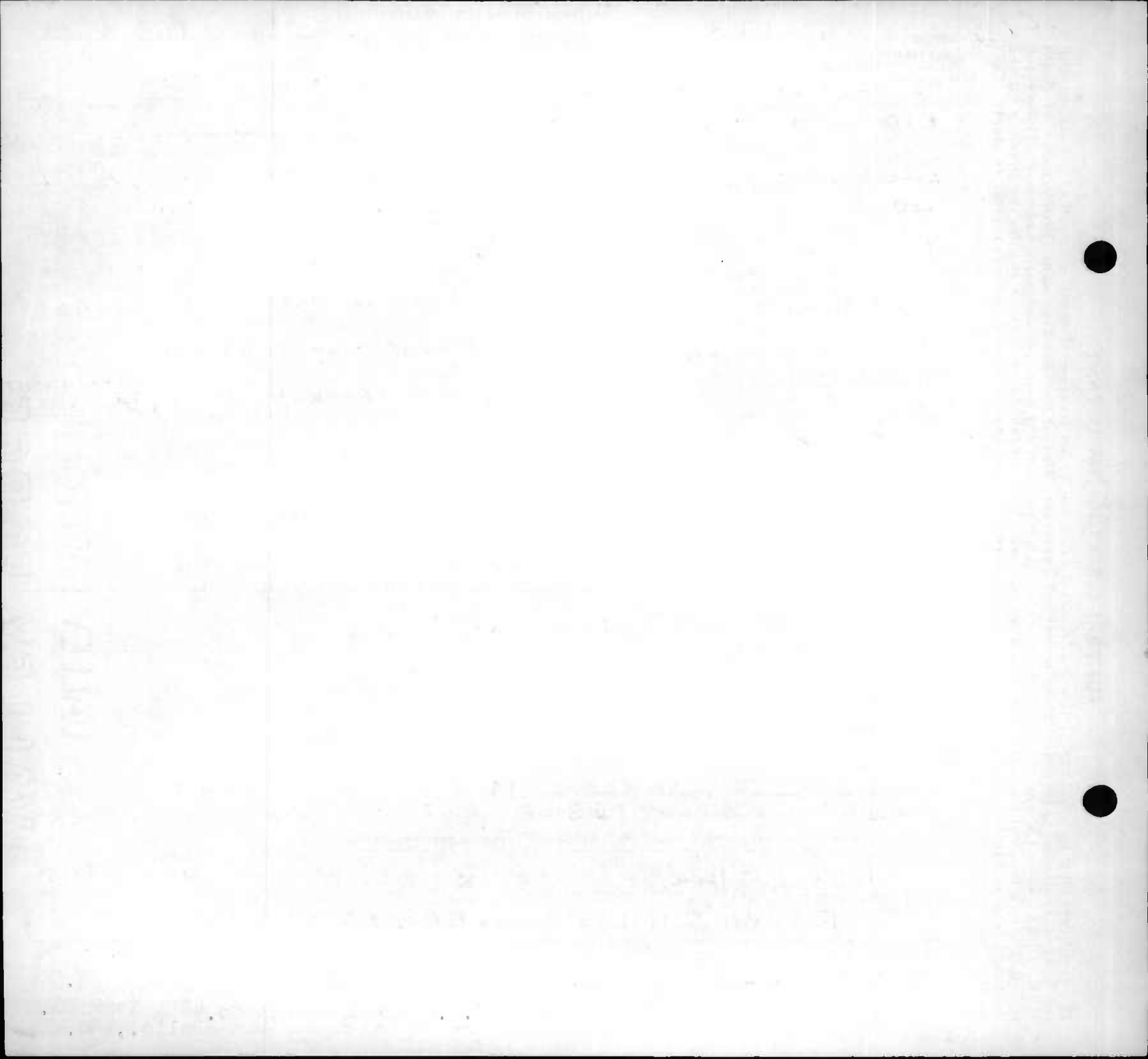
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|-------------------------|---|--|--|---|
| 67 2337 | | CERTIFICATE OF DEATH | | 67 2337 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) SKALLERUP, WALTER T. SR. | | | 2. DATE AND HOUR OF DEATH 3/7/67 1015 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE DISTRICT OF COLUMBIA B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION JOHN'S HOPKINS HOSPITAL 33 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) WASHINGTON, D.C. V-48 | | |
| | | | D. STREET ADDRESS (If rural, give location) 1313 28th St. N.W. | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 10/10/189 | 9. AGE (in years last birthday) 77 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Food Broker | 11. BIRTHPLACE (State or foreign country) Chicago, Illinois | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME James Skallerup | | | 14. MOTHER'S MAIDEN NAME MIDDE (MITTA) JENSEN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES NAVY | | 16. SOCIAL SECURITY NO. 188-14-6982 | 17. INFORMANT WALTER T. SKALLERUP ADDRESS 1155 CREST LANE MELEAN, VA. (SON) | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA (A) DUE TO ANTECEDENT CAUSES (B) DUE TO CHRONIC LUNG DISEASE + EMPHYSEMA (C) DUE TO II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CVA | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>2/12</u> 19 <u>67</u> to <u>3/7</u> 19 <u>67</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>3/7</u> 19 <u>67</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Allen Ginsberg | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/7/67 |
| 23C. PHYSICIAN'S NAME (Type) ALLEN GINSBERG | | | 23D. ADDRESS J. H. Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 3/8/1967 | | 24C. NAME OF CEMETERY or CREMATORY Greenmount | |
| 24D. LOCATION Baltimore, | | 24E. LOCATION (City, town, or county) (State) Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 25B. NAME OF REGISTRAR H. W. Jenkins | | 25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Maryland | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2338 | |
|---|---------------------|--|---|--|--|
| BIRTH NO. 67 2338 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) BARBARA JACOBS CLEAVES (MRS WILLIS E) | | | | MAR 7 1967 2 ⁰⁰ PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND RIDING IN CAR IN BALTIMORE | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 3807 FENCHURCH RD | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL HOSPT. (D.O.A.) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MD 12-01 | |
| D. STREET ADDRESS (If rural, give location) 3807 FENCHURCH RD. | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH JULY 19 1901 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BOSTON MASS. |
| 12. CITIZEN OF WHAT COUNTRY? MARYLAND | | | 13. FATHER'S NAME ARTHUR LINCOLN JACOBS | | |
| 14. MOTHER'S MAIDEN NAME JENNIE MAY ALDRICH | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, go or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. 216-48-8887 | | | 17. INFORMANT ARTHUR FRANKLIN JACOBS BROTHER | | |
| 18. 733.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MOYOCARDITIS, CARDIAC | | | ADDRESS 25 CHRISTOPHER NY 10014 | | |
| 19. II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIO SCLEROSIS | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) NO | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1963 19 to MAR 7 1967, that (I) (we) last saw the deceased alive on FEB 28 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ralph G. Hills | | | | 23B. DATE SIGNED MAR 7, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) RALPH G. HILLS | | | | 23D. ADDRESS 16 EAGER ST BALTO 21202 MD | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 3-8-67 | | 24C. NAME OF CEMETERY or CREMATORY Greenmount | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | | |
| 25B. NAME OF REGISTRAR Philip E. Talley | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | | |
| 25D. ADDRESS 4905 York Rd. Balto., Md. | | | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

(Bronislawa) BERTHA L. MECINSKI

2. DATE AND HOUR PRONOUNCED DEAD

3-8-67

4:55 AM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)44
99 UNION MEMORIAL HOSPITAL - DOA4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2909 Echodale Avenue 21214

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Married

8. DATE OF BIRTH

August 30, 1894.

9. AGE (In years
last birthday)
72If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Austria-Poland

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Leon Grzegorzak

14. MOTHER'S MAIDEN NAME

Leonnarda Popiacki

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)
No16. SOCIAL
SECURITY NO.

213-48-8647

17. INFORMANT

Miss Isabella H. Mecinski

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) ~~X~~

Arteriosclerotic cardiovascular disease

associated with diabetes mellitus

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

3-8-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/11/67.

23C. NAME of CEMETERY or CREMATORY

Holy Rosary Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck, Inc. Balto. Md. 21214

WALTON'S FORTS

VALLEY PRIMER

THE VALLEY PRIMER
A COMPANION TO THE
WALTON'S FORTS
PUBLISHED BY
THE VALLEY PRIMER
PUBLISHERS
100 N. 10th St.
ST. PAUL, MINN.
1900



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------|--|---|--|--|---|--|--|----------------------------------|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>67 2340</u> | | | | |
| BIRTH NO. <u>67 2340</u> | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>LUCILLE A. LAWE</u> | | | | | 2. DATE AND HOUR OF DEATH <u>3/7/67</u> <u>12:15 P.M.</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Mayland General Hospital</u> <u>4-8</u> | | | | | A. STATE <u>Maryland</u> | | | | |
| | | | | | B. COUNTY | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write <u>DATA</u> and give township) <u>Balto</u> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>1719 Tangle St</u> | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u> | | | 8. DATE OF BIRTH <u>1/2/01</u> | 9. AGE (In years last birthday) <u>66</u> | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Walter Wrgancki</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | | 16. SOCIAL SECURITY NO. <u>218-09-0909</u> | | 17. INFORMANT <u>Son - M. Lane</u> | | |
| 18. <u>410X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <u>Pulmonary edema & hemorrhage</u> DUE TO <u>mitral stenosis (Rheumatic heart disease)</u> (B) <u>Intestinal infarction</u> DUE TO <u>Rheumatic mitral stenosis</u> (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/12</u> 19 <u>67</u> to <u>3/7</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/7</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Donald Feldner</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>3/7/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Donald Feldner</u> | | | | | 23D. ADDRESS M.D. <u>877 Linden Ave</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>3-11-67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>HOLY ROSARY</u> | | 24D. LOCATION (City, town, or county) (State) <u>GERMAN HILL RD. Md</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1967</u> | | | 25B. NAME OF REGISTRAR <u>JOHN G. ZEILER</u> | | | 25C. FUNERAL DIRECTOR <u>KIRBY M. ZEILER</u> ADDRESS <u>5608 GARDENVILLE Ave</u> | | | |

2000

2000

2000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BENJAMIN H. LEWIS

2. DATE AND HOUR PRONOUNCED DEAD

3-8-67

11:35 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1907 LAURETTA AVENUE - Amb. Crew #12

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 20-01
1907 Lauretta Avenue 21223

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Jan. 22, 1891

9. AGE (In years
last birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Lazbener Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Hartford Co. Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Robert Lewis

14. MOTHER'S MAIDEN NAME

Mae Corris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Sarah Lewis 213 Franklin St.

ADDRESS

Belair Mt.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

ACTUAL
SIGNATURE

Russell S. Fisher

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

3-8-67

EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/11/1967

23C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

23D. LOCATION

Balto. Md.

(City, town, or county)

(State)

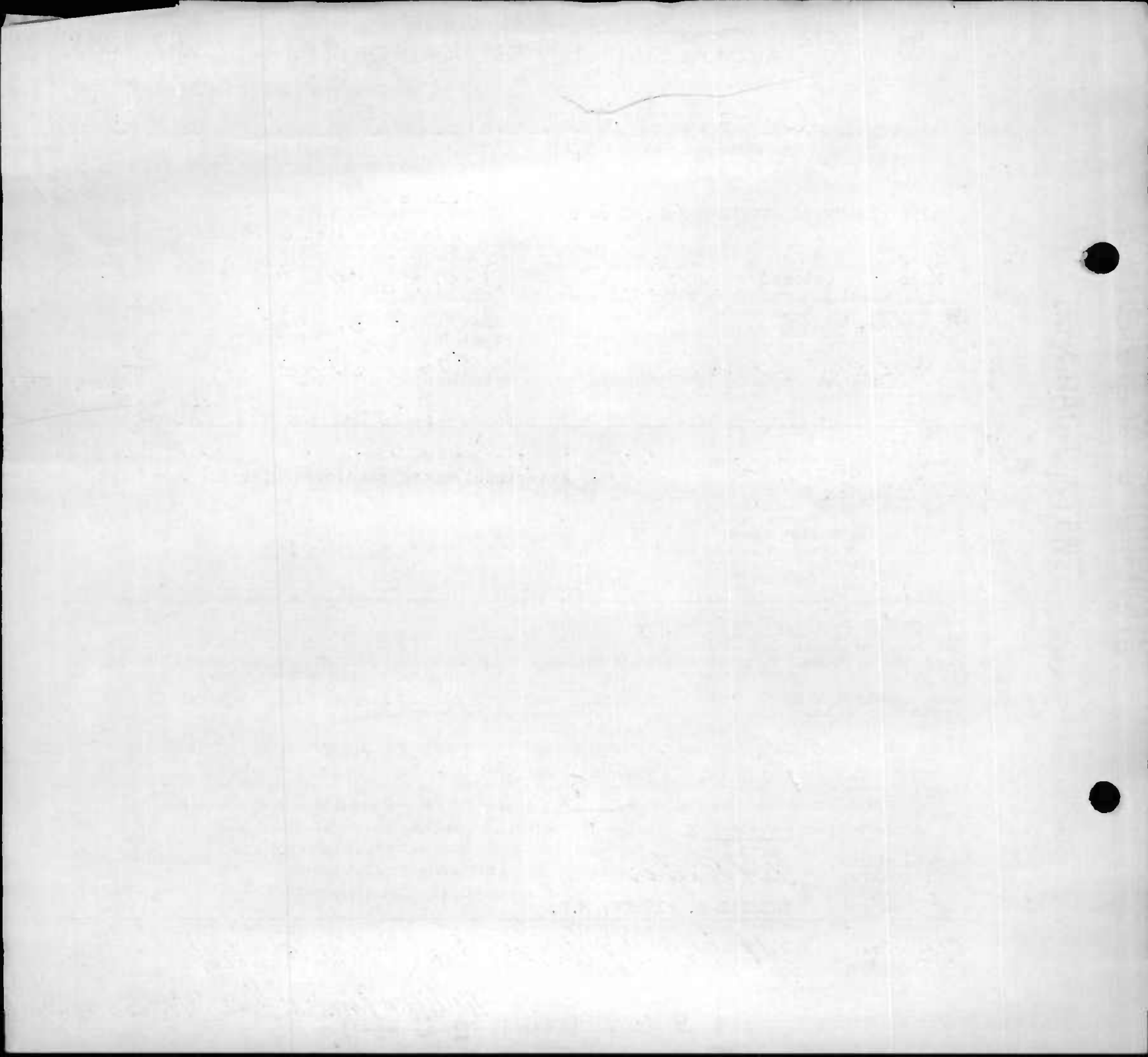
24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Williams Funeral Home 319 W. Schroeder St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 34-33-84 | |
|--|---------------------|---|--|---|--|--|--|
| BIRTH NO. 67 2342 | | M.E. CASE NO. 67 03555 | | | | | |
| 1. NAME OF DECEASED (Type or Print) Robinson, Burt | | | | 2. DATE AND HOUR OF DEATH 3-7-67 7:51 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND University Hospital FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Greene St. 38 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 4-02 D. STREET ADDRESS (If rural, give location) 701 W. Mulberry St. | | | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never married | | 8. DATE OF BIRTH 2-17-67 | 9. AGE (In years last birthday) 2 yrs. | 10. If Under 1 Yr. Months: Days: Hours: Min. 18 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William E Bulley | | | | 14. MOTHER'S MAIDEN NAME Bertha Robinson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Bertha Robinson 701 W. Mulberry ADDRESS | | | |
| 18. 756.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bowel Obstruction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hirschprung Dis. (suspected) INTERVAL BETWEEN ONSET AND DEATH Birth | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 3-7-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bowel Obstruction | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-6 19 67 to 3-7 19 67 , that (I) (we) last saw the deceased alive on 3-7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Robert W. McCurdy M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3-7-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/9/67 | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR 1967020 | | 25C. FUNERAL DIRECTOR Williams Funeral Home | | ADDRESS 319 N. School St. | |

Edmunds
University Hospital
Green St.

W C

William E. Bailey
No

W9
Bath, water
501 W. Walpole St
3-17-67 5 mts 18

W9
Bertie Robinson

Bowel Obstruction
Hirschsprung's Dis (suspected) Birth

3-5-67 Bowel Obstruction

Robert W. McGuffey

3-5-67
3-5-67
3-5-67
3-5-67

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 2343 | |
|--|-------------------------|--|--|--|--|--|--|--|--|---|--|
| BIRTH NO. 67 2343 | | CERTIFICATE OF DEATH | | | | | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MICHAEL J. CONWAY | | | | | | 2. DATE AND HOUR OF DEATH MARCH 6, 1967 1:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO. 30, MD. | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) 1706 MONTREY STREET | | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 9-7-09 | | 9. AGE (In years last birthday) 57 | | If Under 1 Yr. Months: Days: Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED | | | | 10B. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME MICHAEL Conway | | | | | | 14. MOTHER'S MAIDEN NAME EMMA SMITH | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 220-05-3826 | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AV | | | | | |
| 18. 103.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gram Negative Shock (A) DUE TO | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2-3 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Bacterial Infection (B) DUE TO | | | | | | | | | | 4-6 days | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma of the Cecum (C) DUE TO | | | | | | | | | | 6+ months | |
| 19A. DATE OF OPERATION 2/27/67 | | | | | | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction | |
| 20A. AUTOPSY? (Yes or No) NO | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 22 19 67 to MARCH 6 19 67 , that (I) (we) last saw the deceased alive on MARCH 6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Frank M. Detorie | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 3/6/67 | |
| 23C. PHYSICIAN'S NAME (Type) FRANK M. DETORIE | | | | | | 23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-8-67 | | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | | | 25B. NAME OF REGISTRAR R. E. Hubbard | | | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|----------------------|--|------------------------------|--|-----------------------------|
| BIRTH NO. 67 2344 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2344 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | BURRIER CALVIN A | | 2. DATE AND HOUR OF DEATH 3-7-67 12:34AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY | | BALTO. CO | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | |
| 40 28K. ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTO. 29, MD. | | D. STREET ADDRESS (If rural, give location) | | 2201 GAYLAWN DR. BALTO. 27 | |
| 5. SEX MALE | 6. RACE CAUCASION | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 12-18-07 | 9. AGE (In years lost birthday) 59 | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| IRON WORKER | | BALTO. GAS & ELEC MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME MILLARD BURRIER DEC'D | | 14. MOTHER'S MAIDEN NAME KATIE STUMP DEC'D | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W W II | | 16. SOCIAL SECURITY NO. 705 14 0871 | | 17. INFORMANT ADDRESS - AVES - ST. AGNES RECORDS: WILKENS & CATON | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) anuria + shock (B) aortic vessel fistula (C) ruptured abdominal aneurysm | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 3/6/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ruptured abd. aneurysm | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 5, 19 67 to MARCH 7, 19 67, that (I) (we) lost saw the deceased alive on MARCH 7, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jaime V. del Pilar | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/7/67 | |
| 23C. PHYSICIAN'S NAME (Type) JAIME V. DEL PILAR | | 23D. ADDRESS M.D. 51 AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-9-1967 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION 3801 Frederick Ave., Balto., Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 25B. NAME OF REGISTRAR Howard H. Hubbard | | 25C. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229 | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|------------------|---|-----------------------------|--|-------------------------------------|
| BIRTH NO. 67 2345 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2345 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MC DONALD, JAMES EDWARD | | 2. DATE AND HOUR OF DEATH MARCH 6, 1967 | | 11:45A | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2526 WASHINGTON BLVD. 21230 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4-24-03 | 9. AGE (In years last birthday) 63 | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DISABLED | | 10B. KIND OF BUSINESS OR INDUSTRY XXXXXX DISABLED | | 11. BIRTHPLACE (State or foreign country) MARYLAND | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME JAMES E. Mc Donald | | 14. MOTHER'S MAIDEN NAME MARGARET CONNELLY Connolly | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) BLEEDING DUODENAL ULCER - (B) CARDIAC ARREST. (C) MYOCARDIAL INFARCTION ? | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 17 1967 to MARCH 6 1967, that (I) (we) last saw the deceased alive on MARCH 6 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) JUAN S. CABRERA | | | | 23D. ADDRESS 21229 ST. AGNES HOSP; CATON & WILKENS AVES. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-9-1967 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 25B. NAME OF REGISTRAR Robert E. Hubbard | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

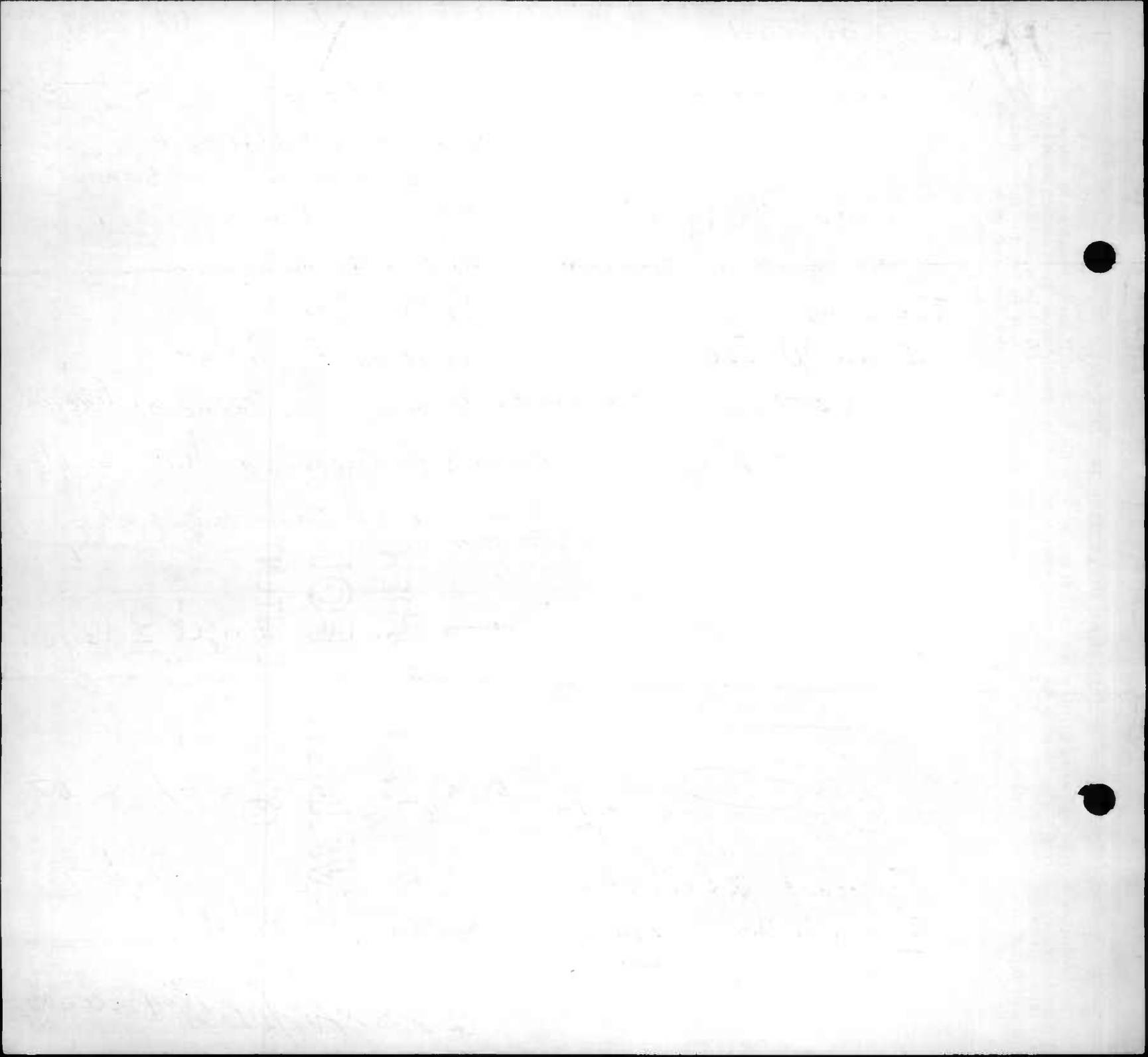
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 2346 | |
|--|--|---|---|--|--|---|--|
| BIRTH NO. 67 2346 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Annie Clayton | | 2. DATE AND HOUR OF DEATH March 6, 1967 2:45 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2503 Elsimore Ave | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1708 W. Lafayette Av | | | |
| 5. SEX Female | 6. RACE Col. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH July 18, '85 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months Days Hours Min. | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME ? McQuay | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Thelma Thomas 1708 W. Lafayette Av | | | |
| 18. 42211 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Vascular Disease DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH 12 years | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-5 1955 to 3-6 1967 , that (I) (we) last saw the deceased alive on 3-1 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE William D. Watts M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3-8-67 | |
| 23C. PHYSICIAN'S NAME (Type) William D. Watts M.D. | | | | 23D. ADDRESS 515 N. Avenue to 4th St. Baltimore Md 21227 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-9-67 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | 25B. NAME OF REGISTRAR Blair E. Ferguson | | 25C. FUNERAL DIRECTOR M. J. ... | | ADDRESS 118 W. Biddle St. | |

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

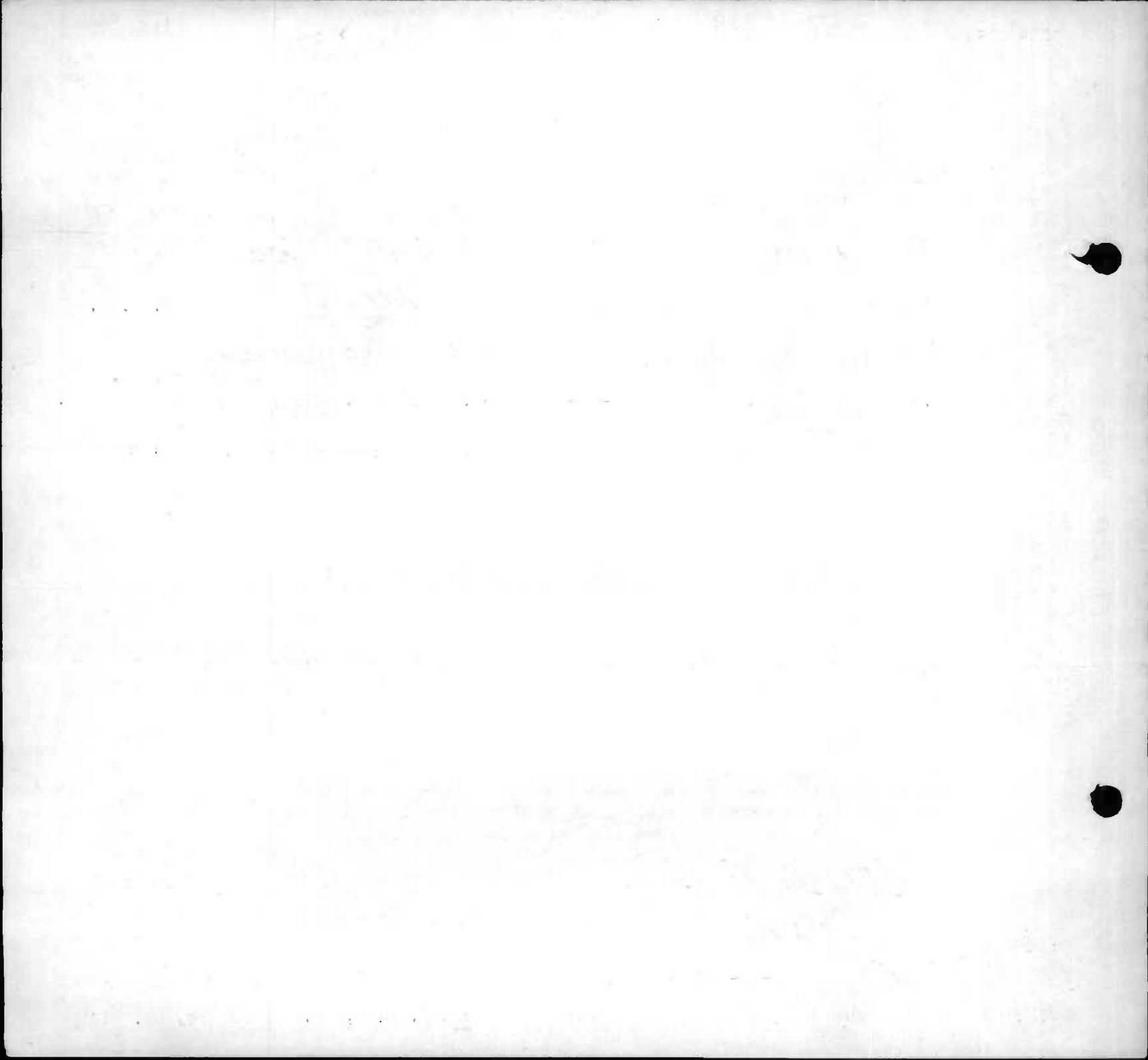
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|---|---------------|--|-------------------------------|--|-----------------------------|
| BIRTH NO. 67 2347 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2347 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Lee, Walker | | 2. DATE AND HOUR OF DEATH 3/7/67 5 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pikesville 53-00 | | | |
| D. STREET ADDRESS (If rural, give location) 37 Bend Ave | | | | | |
| 5. SEX male | 6. RACE negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 2/19/1904 | 9. AGE (In years lost birthday) 63 | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teamster | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME John W. Lee | | | |
| 14. MOTHER'S MAIDEN NAME Rebecca F. Parker | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | |
| 16. SOCIAL SECURITY NO. 219-14-1010 | | 17. INFORMANT Wife. Same as deceased | | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral Vascular accident, 3 days (B) Arteriosclerotic Cardiovascular disease (C) DISEASE | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bacterial Pneumonia 2 days | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/3/67 to 3/7/67, that (I) (we) last saw the deceased alive on 3/7/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Erwin A. Hesselberg | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/7/67 | |
| 23C. PHYSICIAN'S NAME (Type) Erwin A. Hesselberg | | 23D. ADDRESS Sinai Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) 3/11/67 | | 24B. DATE 3/11/67 | | 24C. NAME OF CEMETERY or CREMATORY St. Luke cem | |
| 24D. LOCATION (City, town, or county) (State) Pikesville md | | 25A. DATE REC'D BY HEALTH DEPT. MAR 9 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Erwin A. Johnson | | | |
| 25D. ADDRESS 1804 McCulloch St | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2348 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2348 | |
|--|---------------------|--|--|---|---|
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) <u>Clara K. Welsh</u> | | | 2. DATE AND HOUR OF DEATH <u>3/6/67</u> <u>19¹⁰</u> <u>P</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>34 Bon Secour Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Balto.</u> <u>53-00</u> D. STREET ADDRESS (If rural, give location) <u>6807 Richardson Rd.</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>1-14-17</u> | 9. AGE (In years last birthday) <u>50</u> | If Under 1 Yr. Months: Days Hours Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Food Market</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | |
| 13. FATHER'S NAME <u>Martin B. Marshall</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u> | | | 16. SOCIAL SECURITY NO. <u>220-16-1135</u> | | |
| 17. INFORMANT <u>Mr. Charles W. Welsh, 6807 Richardson Rd.</u> | | | 18. 430.01 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Competitive heart failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>? Idiopathic myocarditis</u> | | |
| 19. DATE OF OPERATION <u>2</u> | | | 20. AUTOPSY? (Yes or No) <u>No</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/> | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | |
| 21F. HOW DID INJURY OCCUR? | | | 21G. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>In Baltimore City</u> | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-4-1967</u> to <u>3-6-1967</u> , that (I) (we) last saw the deceased alive on <u>3-6-1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | 23B. DATE SIGNED <u>3/6/67</u> | | |
| 23A. SIGNATURE <u>Octavio A. Ruiz</u> | | | 23C. PHYSICIAN'S NAME (Type) <u>Octavio A. Ruiz</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>3-9-67</u> | | |
| 24C. NAME OF CEMETERY or CREMATORY <u>Mountain View Cemetery</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Sharpsburg, Maryland</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 9 1967</u> | | | 25B. NAME OF REGISTRAR <u>John E. East, Jr.</u> | | |
| 25C. FUNERAL DIRECTOR <u>Boonsboro, Md. 21713</u> | | | 25D. ADDRESS | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|---|-------------------------------------|--|--|--|--|---|---|
| BIRTH NO. 67 2349 | | | | | CERTIFICATE OF DEATH | | Registered No. 67 2349 | | |
| 1. NAME OF DECEASED (Type or Print) <i>George B. Carlin</i> | | | | | 2. DATE AND HOUR OF DEATH <i>3/8/67</i> <i>5 A</i> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>00 1220 Washington Blvd.</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>21-02</i> D. STREET ADDRESS (If rural, give location) <i>1220 Washington Blvd. (21230)</i> | | | | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>7-24-09</i> | 9. AGE in years lost birthday <i>57</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i> | | 11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>George Carlin</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Blanche Eubert</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES W.W.II</i> | | | 16. SOCIAL SECURITY NO. <i>✓</i> | | 17. INFORMANT <i>Violetta Carlin - 1220 Washington Blvd.</i> | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) I. <i>163X I</i> CAUSE OF DEATH (A) <i>Carcinoma left lung</i> (B) <i>Interval between onset and death</i> (C) <i>Remember</i> | | | | | II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/13</i> 19 <i>65</i> to <i>3/8</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3/7</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>John P. Urlock Jr</i> M.D. | | | | | 23B. DATE SIGNED <i>3/8/67</i> | | | 23C. PHYSICIAN'S NAME (Type) <i>JOHN P. URLOCK JR</i> M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | | 24B. DATE <i>3/10/67</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem</i> | | |
| 24D. LOCATION (City, town, or county) (State) <i>5301 Frederick Ave</i> | | | | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 10 1967</i> | | | | |
| 25B. NAME OF REGISTRAR <i>W. E. Hall</i> | | | | | 25C. FUNERAL DIRECTOR <i>John J. C. Manslow Inc</i> | | | | |
| 25D. ADDRESS <i>987 St. 23 Md.</i> | | | | | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 2350 | |
|---|--|---|--|---|--|---|--|
| BIRTH NO. 67 2350 | | | | | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Benjamin E. Brewer</i> | | | | 2. DATE AND HOUR OF DEATH <i>3/7/67 7 P. M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>1117 Sargeant St.</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind.</i> B. COUNTY <i>Baltimore</i> | | | |
| 5. SEX <i>male</i> | | | | 6. RACE <i>white</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>unmarried</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Balto City</i> | | 8. DATE OF BIRTH <i>6/17/1891</i> | |
| 13. FATHER'S NAME <i>Tom E. Brewer</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Mary E. Grone</i> | | 9. AGE (In years last birthday) <i>75</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NU</i> | | | | 16. SOCIAL SECURITY NO. <i>-</i> | | 17. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) DUE TO <i>Arteriosclerotic Cardio Vascular Disease</i> (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3/7 3/7 19 67</i> to <i>3/7 19 67</i> that (I) last saw the deceased alive on <i>3/7 19 67</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>John P. Urlock Jr.</i> | | | | M.D. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>3/8/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>JOHN P. URLOCK JR</i> | | | | 23D. ADDRESS <i>1227 Washington Blvd</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3/11/67</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>22nd St. Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore Ind.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 10 1967</i> | | 25B. NAME OF REGISTRAR <i>R. O. G. E. F. F.</i> | | 25C. FUNERAL DIRECTOR <i>John J. G. G. G. G.</i> | | ADDRESS <i>23rd St.</i> | |

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6-635 67 2351

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2351

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES V. GARDNER (GRZECHOWIAK)

2. DATE AND HOUR OF DEATH

March 7, 1967

6:10^P_M

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland, Baltimore C.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Dundalk

D. STREET ADDRESS (If rural, give location)

2709 Gray Manor Terrace #21222

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

7-9-01

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months: Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer, Sanitation Dept. Balto. Co.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph Gardner

14. MOTHER'S MAIDEN NAME

Elizabeth Moksacki

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.
216-10-393217. INFORMANT BCH 4940 Eastern Avenue ADDRESS
RECORDS: Baltimore, Maryland #21224

18. 237X1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) INTROVENTRICULAR
DUE TO HEMORRHAGE

3 DAYS

(B) 2 BRAIN TUMOR
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3/4 19 67 to 3/7 19 67,
that (I) (we) last saw the deceased alive on 3/7 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

3/7/67

23C. PHYSICIAN'S
NAME (Type)

Stuart Beal Silver

23D. ADDRESS

4940 Eastern Avenue

Baltimore, Maryland #21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/13/67

24C. NAME of CEMETERY or CREMATORY

Holly Hill Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAR 10 1967

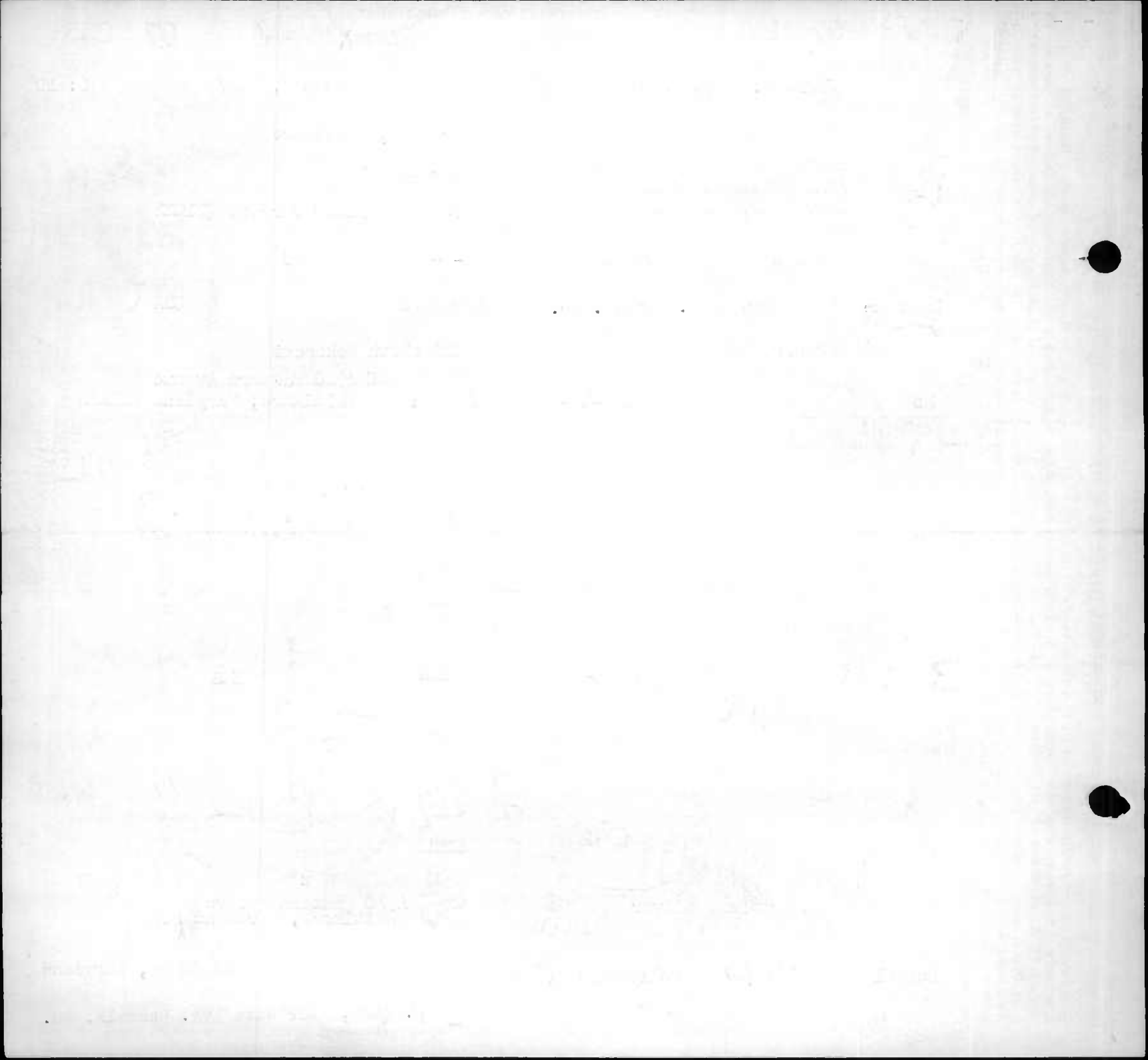
25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

John J. Duda, 7922 Wise Ave. Dundalk, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 67 2352

BIRTH NO. 67 2352

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

CATHERINE EDISON

2. DATE AND HOUR OF DEATH

3-8-67

1:10 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

36 FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MD

GREEN HAVEN FORE HUNDEL CO.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

52-00

D. STREET ADDRESS (If rural, give location)

204TH ST + HAYFORD AVE

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

11-23-92

9. AGE (In years last birthday)

74

If Under 1 Yr. Months

Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

ADAM MILLER

14. MOTHER'S MAIDEN NAME

ELIZABETH TOWERS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

HUSBAND

ADDRESS

MR. THAYER E. EDISON (SAME)

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

Ca of gallbladder with liver metastasis

(B) DUE TO

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

3-3-67

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Gallbladder & liver R.O.

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-26 1967 to 3-8 1967, that (I) (we) last saw the deceased alive on 3-8 1:10 PM 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Wilfredo R. Mediano

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

3-8-67

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

M.D.

FRANKLIN SQUARE HOSPITAL

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

3-11-67

24C. NAME OF CEMETERY or CREMATORY

DARKWOOD

24D. LOCATION

(City, town, or county)

(State)

BALTO., MD

25A. DATE REC'D BY HEALTH DEPT.

MAR 10 1967

25B. NAME OF REGISTRAR

Robert E. Sullivan

25C. FUNERAL DIRECTOR

John Walter Calkin

ADDRESS

5444 BELAIR RD

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2353 | |
|---|----------------------|--|--------------------------------|---|--|
| BIRTH NO. 67 2353 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) (Johnie) Johnny L. Hoggard | | 2. DATE AND HOUR OF DEATH 3/7/67 12:03 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital | | A. STATE Maryland 8. COUNTY Baltimore | | | |
| 33 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | 8-06 | |
| | | D. STREET ADDRESS (If rural, give location) 1729 N. Washington St | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 3-5-17 | 9. AGE (In years last birthday) 50 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic | | 10B. KIND OF BUSINESS OR INDUSTRY self-employed | | 11. BIRTHPLACE (State or foreign country) North Carolina | |
| 13. FATHER'S NAME Johnny Hoggard | | 14. MOTHER'S MAIDEN NAME Jennie Bassmore | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-07-5013 | | 17. INFORMANT ADDRESS Mrs. Mamie Hoggard 1729 N. Washington Street | |
| 18. 4-22-11 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Multiple CVA's | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | (B) ASCD | | | |
| ANTECEDENT CAUSES | | (C) | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/15 19 67 to 3/7 19 67 , that (I) (we) last saw the deceased alive on 3/6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John J. Hays | | | | 23B. DATE SIGNED 3/7/67 | |
| 23C. PHYSICIAN'S NAME (Type) John Sergent | | | | 23D. ADDRESS The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial Transit | | 24B. DATE 3-12-67 | | 24C. NAME OF CEMETERY or CREMATORY Hoggard Family Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Bertie Co., N. Carolina | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Marshall W. Jones, Jr. | |
| 25C. FUNERAL DIRECTOR ADDRESS 1735 Harford Ave. | | | | | |

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BALTIMORE CITY HEALTH DEPARTMENT

67 2351

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|--|---------------------------|---|---|
| BIRTH NO. <u>60-31584</u> | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. <u>67 2351</u> | |
| M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) TERRY R LONG | | 2. DATE AND HOUR PRONOUNCED DEAD 3-8-67 8:00 AM | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1715 Aiken Street 21213 | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married | 8. DATE OF BIRTH 10-31-60 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10B. KIND OF BUSINESS OR INDUSTRY none | 9. AGE (In years last birthday) 6 yrs |
| 13. FATHER'S NAME Charles Long | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 14. SOCIAL SECURITY NO. none | | 14. MOTHER'S MAIDEN NAME Betty Herbert | |
| 16. SOCIAL SECURITY NO. none | | 17. INFORMANT ADDRESS Mrs. Betty Long 1715 Aiken St. | |
| 18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) Bronchopneumonia DUE TO (B) Intracerebral hemorrhage - (cerebellum) DUE TO (C) | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Russell S. Fisher | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. | | DATE SIGNED 3-8-67 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 3-13-67 | |
| 23C. NAME of CEMETERY or CREMATORY Baltimore National | | 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | 24B. NAME OF REGISTRAR Phyllis E. Fisher | |
| 24C. FUNERAL DIRECTOR Marshall W. Jones, Jr. | | ADDRESS 1735 Harford Ave. | |

19670002362

WILLY FORGE

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HELEN E. COCOLIN

2. DATE AND HOUR PRONOUNCED DEAD

3-7-67

4:33 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6507 Rosemont Avenue 21206

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

August 2, 1920

9. AGE (In years
last birthday)

46x 46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

US Post Office

11. BIRTHPLACE (State or foreign country)

Canton, Ohio

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Gabriel Takides

14. MOTHER'S MAIDEN NAME

Elizabeth Ruby

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Gus Cocolin, same as 4

ADDRESS

18.

E 976 X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Gunshot wound of head

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

6507 Rosemont Avenue, Baltimore 21206

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour) (Minute)
Between 2:30
3:25 PM

3

7

1967

3:25

PM

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot self in head with .32 cal. revolver

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-8-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

10 March 67

23C. NAME OF CEMETERY or CREMATORY

Glen Haven Memorial

23D. LOCATION

(City, town, or county)

Glen Burnie, Maryland AA

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 10 1967

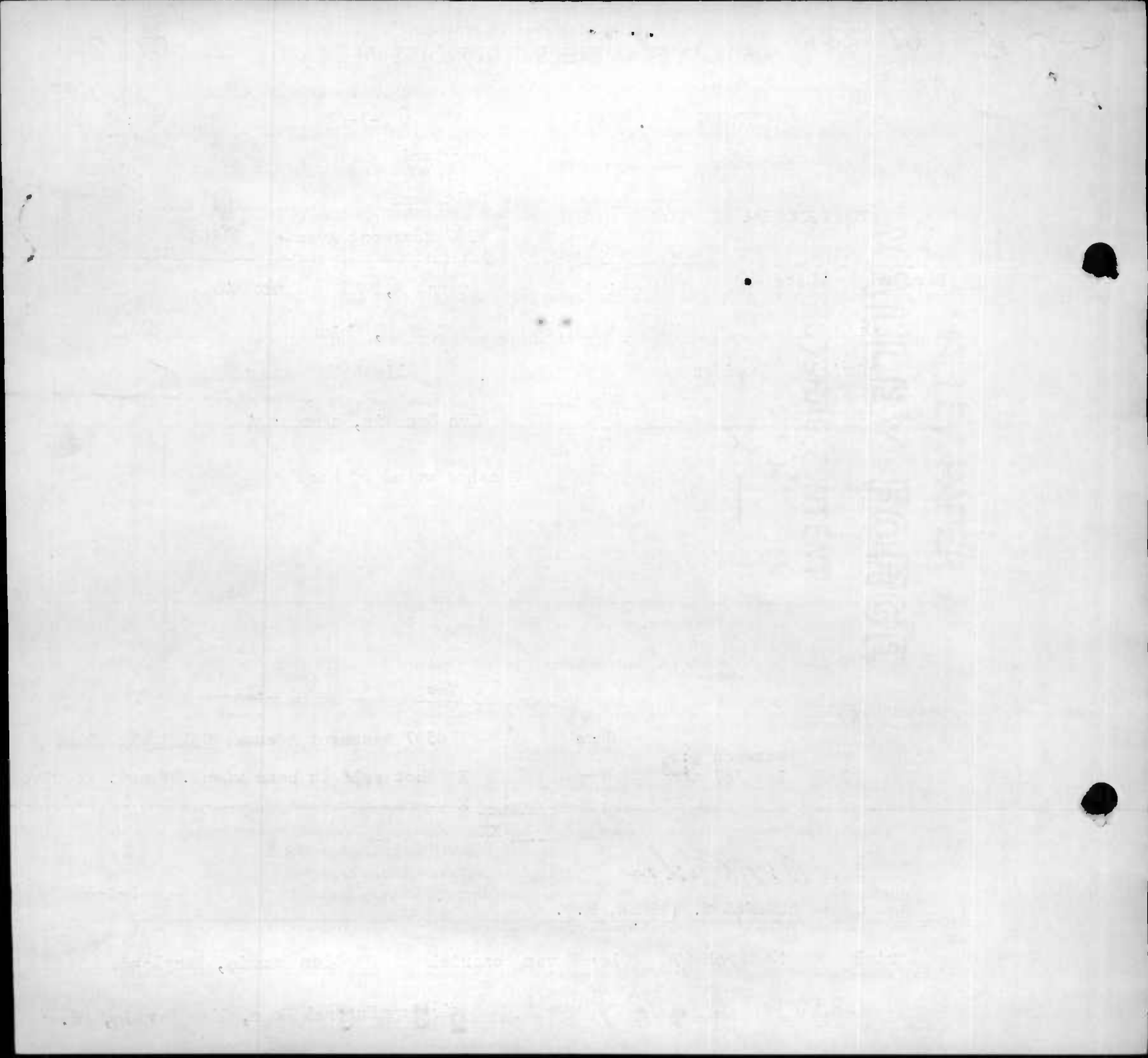
24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Kirkley Funeral Home, Glen Burnie, Md.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2356</u> | |
|---|---------------------|--|---|--|---|
| BIRTH NO. <u>67 2356</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH <u>MARCH 5, 1967</u> <u>7:05 P.M.</u> | | | |
| 1. NAME OF DECEASED (Type or Print) <u>DAVIS, Sandra A.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>34 Bon Secour</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Baltimore</u> B. COUNTY <u>Maryland</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>1233 Delbert Ave</u> <u>26-36</u> D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX <u>7</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>never married</u> | 8. DATE OF BIRTH <u>April 19, 1959</u> | 9. AGE (In years last birthday) <u>7 years</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u> | |
| 13. FATHER'S NAME <u>Davis, Gerard A., Sr.</u> | | 14. MOTHER'S MAIDEN NAME <u>Geraldine Matcuk</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Hospital</u> | |
| 18. <u>237X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Ataxia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebellar tumor?</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>3-3-67</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cerebellar exploration</u> | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>FEB. 20</u> 19 <u>67</u> to <u>MARCH 5</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MARCH 5</u> , 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Edolfo G. de Pena</u> M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/9/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Sacred Heart of Jesus</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore Ct. Maryland</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>Raymond L. Kaczorowski</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>2525 Fleet St.</u> | |

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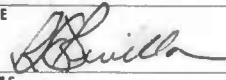
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2357 | |
|--|-------------------------|---|-------------------------------------|---|---|
| BIRTH NO. 67 2357 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH MARCH 6, 1967 5:20 A.M. | | | |
| 1. NAME OF DECEASED (Type or Print) ETHEL EYLER | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Cornell B. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTO. 29, MD. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) SYKESVILLE D. STREET ADDRESS (If rural, give location) PULLEN NURSING HOME | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) UNKNOWN | 8. DATE OF BIRTH 10-16-03 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY UNKNOWN | | 11. BIRTHPLACE (State or foreign country) UNKNOWN Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME UNKNOWN | | | |
| 14. MOTHER'S MAIDEN NAME UNKNOWN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE. | | | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DIABETES | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 4-5 YEARS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 7 19 67 to MARCH 6 19 67 , that (I) (we) lost saw the deceased alive on MARCH 6 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3-6-67 | |
| 23C. PHYSICIAN'S NAME (Type) RODOLFO REVILLA | | 23D. ADDRESS M.D. ST. AGNES HOSPITAL, WILKENS & CATON AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-8-67 | | 24C. NAME OF CEMETERY or CREMATORY Freedom Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Sykesville, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | | |
| 25B. NAME OF REGISTRAR R. E. E. E. E. | | 25C. FUNERAL DIRECTOR ADDRESS Harry W. Haight Sykesville, Md. | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65-30377 67 2358 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2358 | |
|---|-------------------------|---|-------------------------------------|--|--|---|-----------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) STEWART, KIMBERLY D. | | | | 2. DATE AND HOUR OF DEATH MARCH 6, 1967 | | 3:20P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL | | (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | B. COUNTY ANNE ARUNDEL COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) RIVIERA BEACH 52-00 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 238 HARLEM ROAD | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD | 8. DATE OF BIRTH 11-28-65 | 9. AGE (In years last birthday) 15 MONTHS | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD | | 10B. KIND OF BUSINESS OR INDUSTRY CHILD | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME THOMAS STEWART | | | | 14. MOTHER'S MAIDEN NAME DORIS MC GLOTHIN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS 21229 | | | |
| 18. 289.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Prob. secondary to Hypoglycemia | | | | CAUSE OF DEATH (A) DUE TO prob. secondary to Hypoglycemia | | INTERVAL BETWEEN ONSET AND DEATH 3 hours | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO Diarrhea | | | |
| (C) _____ | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 6 19 67 to MARCH 6 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 6 19 67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Humberto J. Hernandez</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED March 6, 1967 | |
| 23C. PHYSICIAN'S NAME (Print) HUMBERTO HERNANDEZ | | | | 23D. ADDRESS St. Agnes Hospital, Balt. Md. - CATON AND WILKENS AVENUES | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-7-67 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Olive Cemetery | | 24D. LOCATION (City, town, or county) (State) Randallstown, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | 25B. NAME OF REGISTRAR Robert E. Fulkerson | | 25C. FUNERAL DIRECTOR Robert H. Straight | | ADDRESS Spokane, Wn. | |

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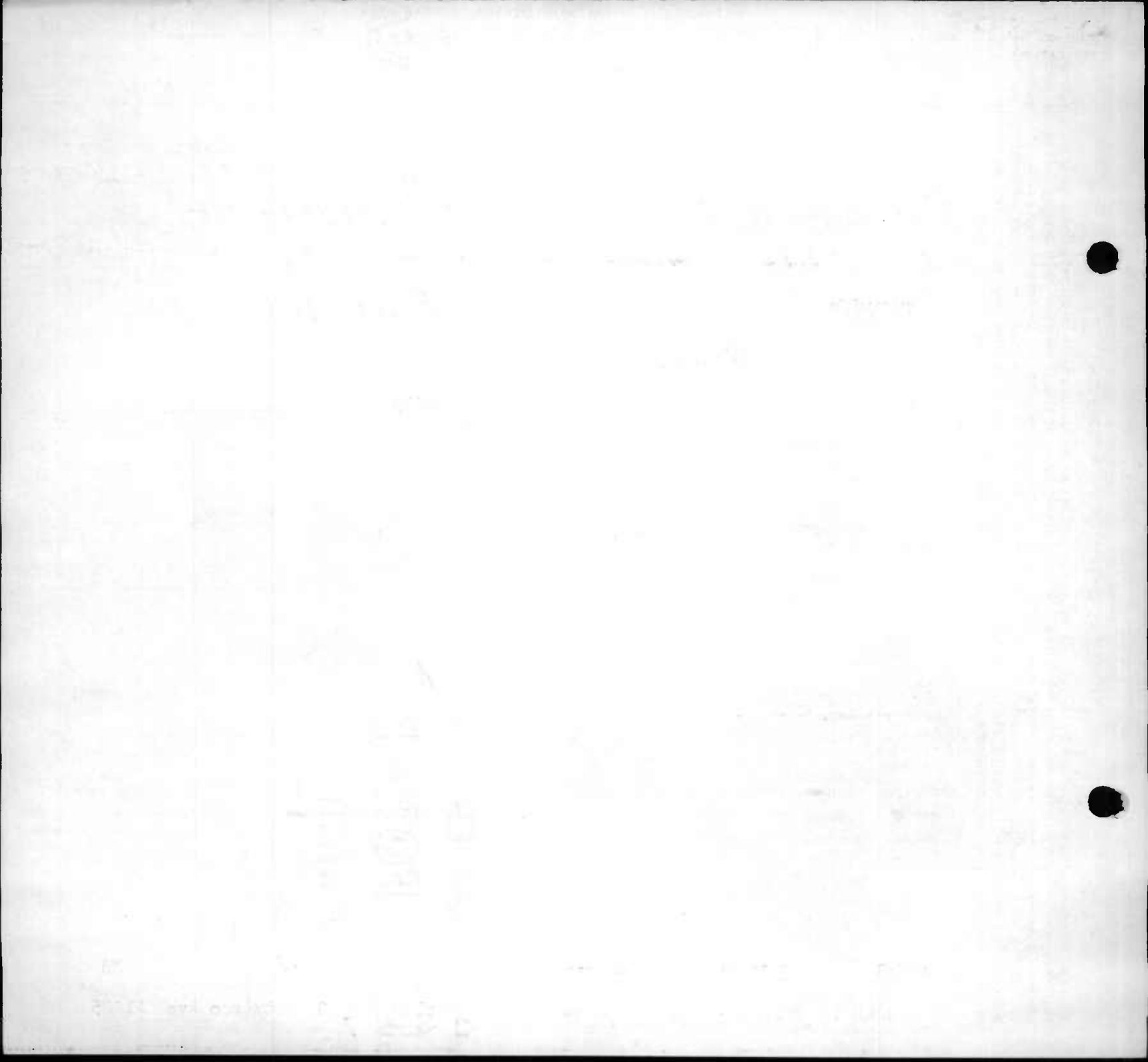
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|-------------------------|---|---|--|---|
| BIRTH NO. | | 67 2359 | | 67 2359 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Florence C. Wayson</i> | | | 2. DATE AND HOUR OF DEATH <i>3-8-67 at 4:25 AM</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hosp.</i> | | | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>#21225 25-04</i> D. STREET ADDRESS (If rural, give location) <i>905 Jeffery St.</i> | | |
| 5. SEX <i>F.</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i> | 8. DATE OF BIRTH <i>74</i> | 9. AGE (In years, months, days) <i>74</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i> | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Family</i> |
| 18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>HASCD (Hypertensive Cerebral Arteriosclerosis)</i> | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <i>CVA 2° to 1, probably thrombotic</i> <i>spont. cerebral</i> <i>longstanding heart failure</i> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from <i>3/2</i> 19 <i>67</i> to <i>3-8</i> 19 <i>67</i> , that we (we) last saw the deceased alive on <i>3-8</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Roberto G. Arellano</i> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>3/8/67</i> |
| 23C. PHYSICIAN'S NAME (Type) <i>ROBERTO G. ARELLANO</i> | | | 23D. ADDRESS <i>South Baltimore GEN. Hosp.</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3/11/67</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Cedar Hill Cem</i> | |
| 24D. LOCATION <i>A A Co</i> | | 24E. LOCATION <i>Md</i> | | 24F. LOCATION <i>Md</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 10 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert G. Arellano</i> | | 25C. FUNERAL DIRECTOR <i>McCully F H</i> | |
| 25D. ADDRESS <i>237 Patapsco Ave</i> | | 25E. ADDRESS <i>21225</i> | | 25F. ADDRESS <i>21225</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 2360 | | | |
|--|--|---|--|--|--|---|--|--|--|---|--|----------------------------------|--|
| BIRTH NO. 67 2360 | | CERTIFICATE OF DEATH | | | | | | Registered No. 67 2360 | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Wilkins, Lena | | | | | | 2. DATE AND HOUR OF DEATH 3-4-67 8:50P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital, Inc. Baltimore, Maryland 21217 | | | | | | A. STATE Maryland | | | | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | | D. STREET ADDRESS (If rural, give location) 1925 Penn. Avenue | | | | | | | |
| 5. SEX Female | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 7-12-84 | | 9. AGE (In years lost birthday) 84 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME ? | | | | | | 14. MOTHER'S MAIDEN NAME ? | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hedd, Lena | | | | ADDRESS 2003 Etting Street | | | |
| 18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | CAUSE OF DEATH (A) Congestive Heart Failure DUE TO (B) A S H D DUE TO (C) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-2-67 19 to 3-4-67 19 that (I) (we) last saw the deceased alive on 3-4-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 23A. SIGNATURE A. Khalig M.D. | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3-6-67 | | | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Khalig | | | | | | 23D. ADDRESS M.D. 1514 Division Street | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/10/67 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral | | 24D. LOCATION Baltimore | | (City, town, or county) (State) Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | | | 25B. NAME OF REGISTRAR Robert E. Fink | | | | 25C. FUNERAL DIRECTOR 14637 P. Carew | | | | | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2361 | |
|--|--|--|--|---|--|
| BIRTH NO. 67 2361 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) HARRIS MR HERBERT S., SR. | |
| 2. DATE AND HOUR OF DEATH 3/8/67 6:55 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME & HOSP. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY | |
| 5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWER | | | | 8. DATE OF BIRTH 8.15.94 9. AGE (In years last birthday) 72 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACH. BETH STEEL | | | | 11. BIRTHPLACE (State or foreign country) N. CAR. | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | 12. CITIZEN OF WHAT COUNTRY? AMER. | |
| 13. FATHER'S NAME THOMAS W. HARRIS | | | | 14. MOTHER'S MAIDEN NAME CARRIE G. HARRIELL | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII | | | | 16. SOCIAL SECURITY NO. 214 14 1678 | |
| 17. INFORMANT ADDRESS CHURCH HOME & HOSP. | | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the stomach ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. metastases to the liver & possibly lung. | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2/10/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of stomach | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2.29.1967 to 3.8.1967 , that (I) (we) last saw the deceased alive on 3.8.1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Francisco Baltazar Jr. M.D. | | | | 23B. DATE SIGNED 3/8/67 | |
| 23C. PHYSICIAN'S NAME (Type) FRANCISCO BALTAZAR JR. M.D. | | | | 23D. ADDRESS CHURCH HOME & HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-13-67 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Freed Rd Baltimore | |
| 24D. LOCATION (City, town, or county) (State) | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | 25B. NAME OF REGISTRAR John E. Fadden | | 25C. FUNERAL DIRECTOR ADDRESS 7500 Harford Road | |

doi:10.1017/S0022292412001700

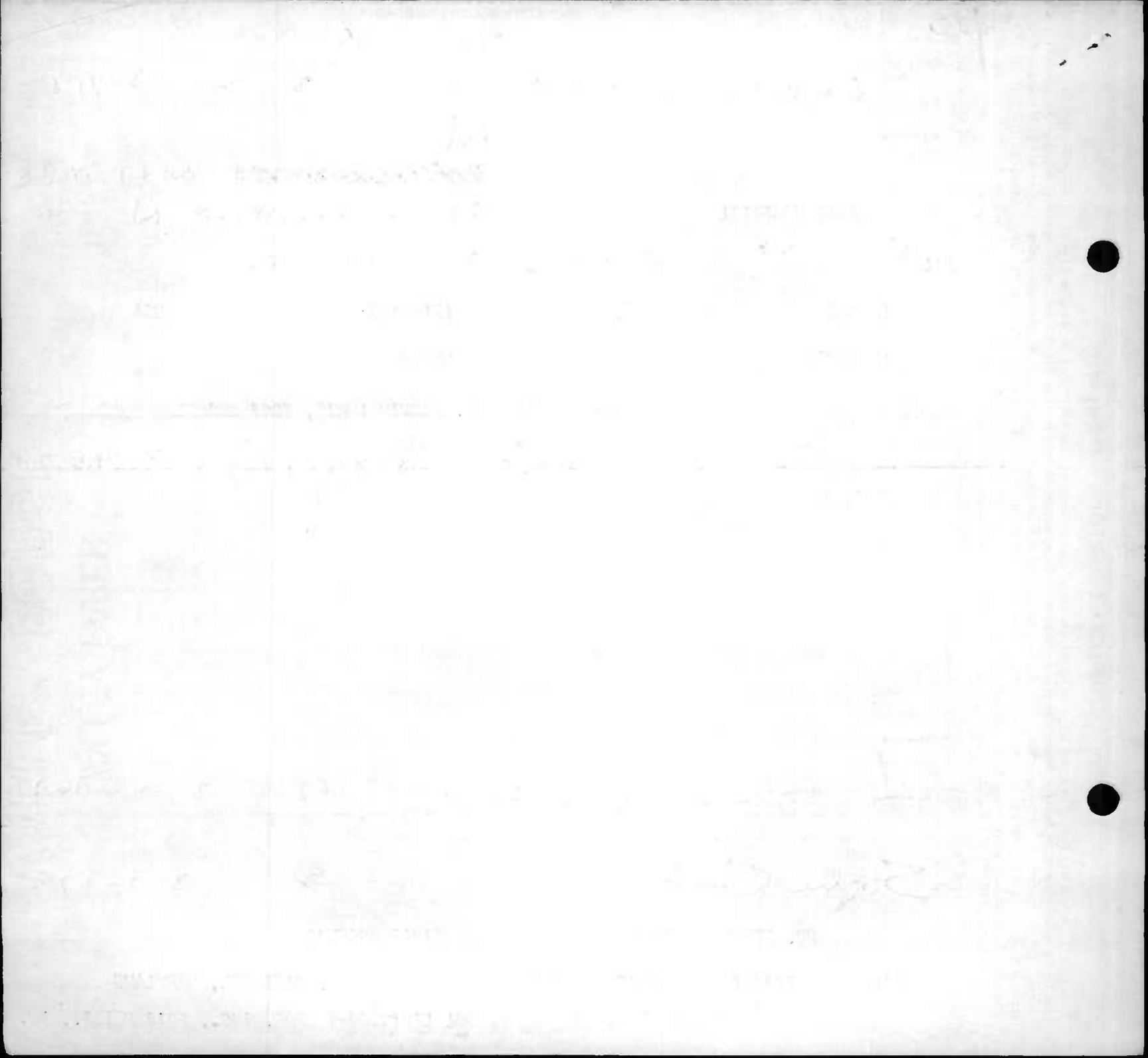
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

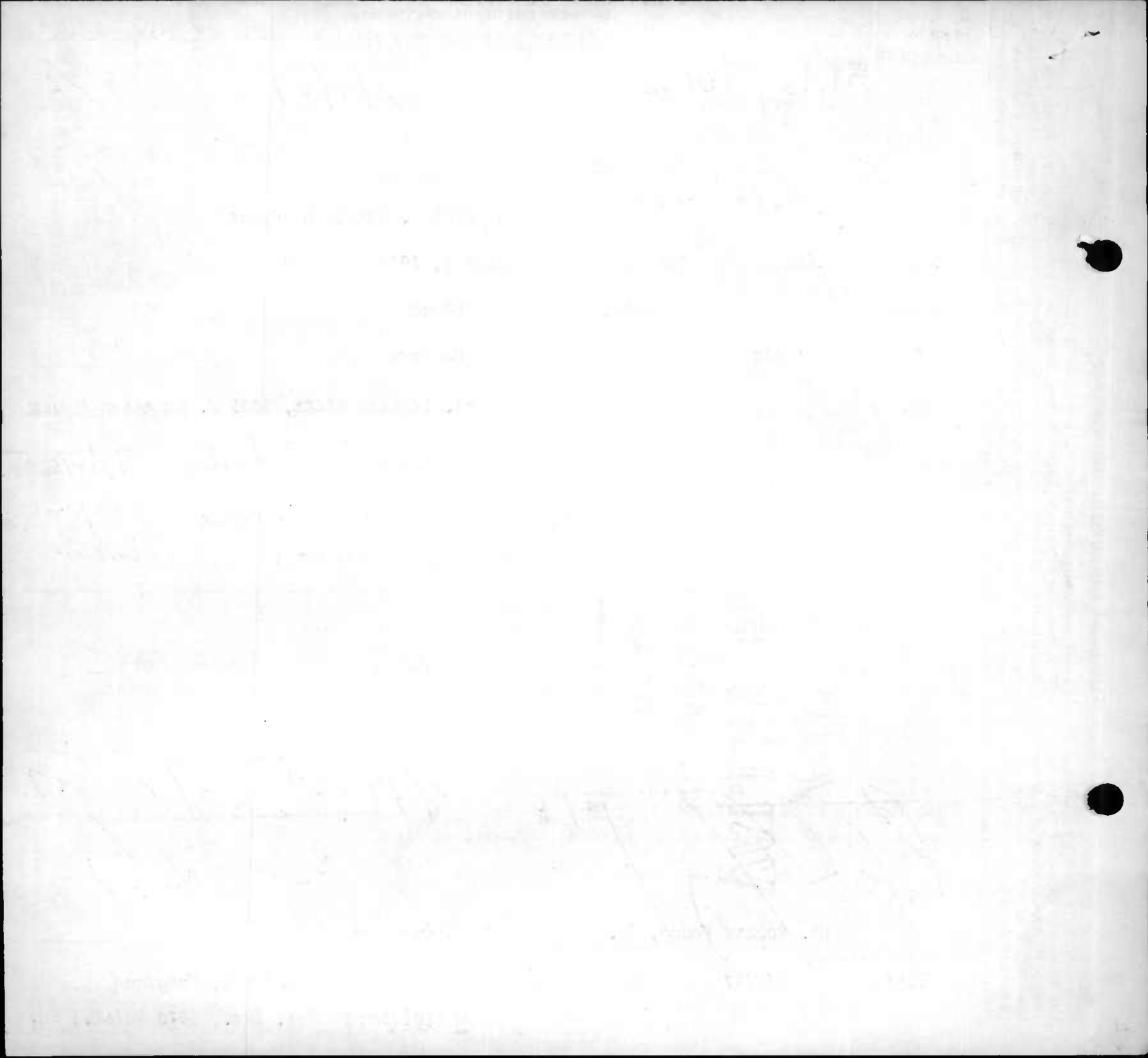
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2362 | |
|--|---|--|--|---|---|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67 2362 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) LURIE, LEVI ISRAEL | | 2. DATE AND HOUR OF DEATH 3-7-67 3:45 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL | | A. STATE Md B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MD | | | |
| | | D. STREET ADDRESS (If rural, give location) 7207 BROMPTON RD 5300 | | | |
| 5. SEX MALE | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 3-17-85 | 9. AGE (In years last birthday) 21 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | 10B. KIND OF BUSINESS OR INDUSTRY RETIRED | | 11. BIRTHPLACE (State or foreign country) LITHUANIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME VALE LURIE | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 373-07-6771 | | 17. INFORMANT ADDRESS MR. MARVIN LURIE, 7207 BROMPTON ROAD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) 163X1 | | CAUSE OF DEATH (A) DUE TO Ca Lung (R) | | INTERVAL BETWEEN ONSET AND DEATH ? YRS. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-2-1967 to 3-7-1967 , that (I) (we) lost saw the deceased alive on 3-7-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Stephen Gordon | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3-7-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS DR. STEPHEN GORDON SINAI HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/9/67 | | 24C. NAME of CEMETERY or CREMATORY CHIZUK AMUNO | |
| 24D. LOCATION BALTIMORE, MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | 25B. NAME OF REGISTRAR SOL LEVINSON | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC., 6010 REIST., RD. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

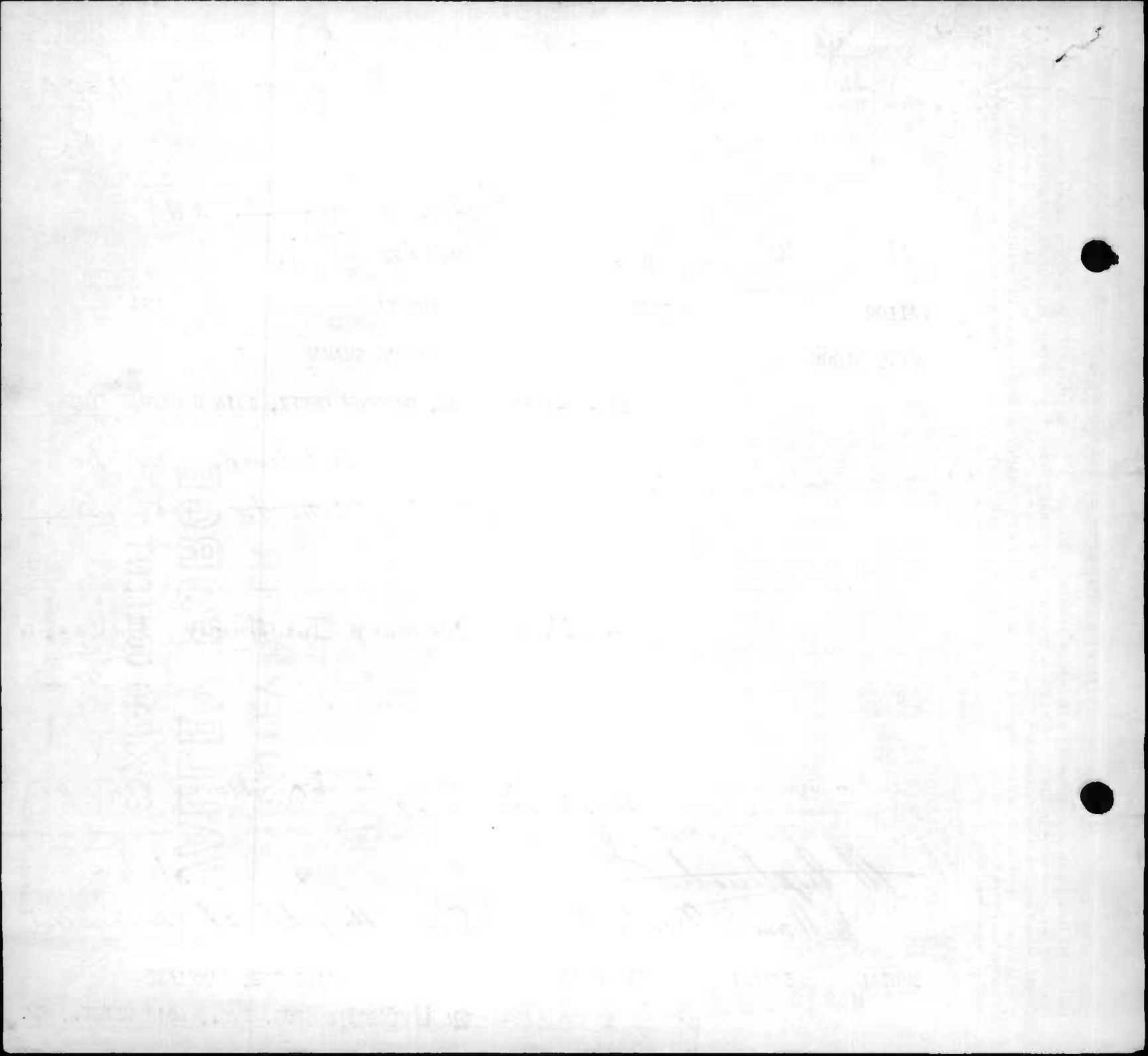
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------|--|---|--|---|
| BIRTH NO. 67 2363 | | CERTIFICATE OF DEATH | | 67 2363 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Blitz, Julius | | 3/8/67 7 ²⁵ /A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| Sinai Hospital of Baltimore | | | Maryland | | |
| 42 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 3005 W. Garrison Avenue | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days: Hours: Min. |
| Male | White | Married | June 5, 1900 | 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Baker | | Retail | | Poland | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| ? Blitz | | | USA | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | Mrs. Lillian Blitz, 3005 W. Garrison Avenue | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTecedent CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/19/67 to 3/8/67, that (I) (we) last saw the deceased alive on 3/8/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Dr. Robert Young, Jr. | | | | 3/8/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Dr. Robert Young, Jr. | | Sinai Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 3/9/67 | | Rudomer Verein | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 10 1967 | | Robert E. Johnson | | Soo Levinson & Bros. Inc., 6010 Reist., Rd. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2364 | |
|---|--|--|--|------------------------------------|--------------------------------|
| BIRTH NO. 67 2364 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Abraham Bloom | | | |
| 2. DATE AND HOUR OF DEATH | | March 8th 1967 11.55 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| Sinai Hospital of Baltimore | | A. STATE Md. B. COUNTY Balt Co. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| 42 | | Baltimore 53-00 | | | |
| D. STREET ADDRESS (If rural, give location) | | 2916 B Marnat Rd. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Wid. | 8. DATE OF BIRTH 10/1/76 | 9. AGE (In years last birthday) 90 | 10. If Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| TAILOR | | SHOP | RUSSIA | | USA |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| DAVID BLOOM | | | HANNAH SHANAH ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| NO | | 215-03-4690 | MRS. DOROTHY GERTZ, 2916 B MARNAT ROAD | | |
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) Electrolyte Imbalance 24 hr. | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (B) Intestinal Obstruction 5 days | | | |
| ANTECEDENT CAUSES | | (C) | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| ASCVD | | Coronary Insufficiency Unknown | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 25 1967 to March 8th 1967, that (I) (we) last saw the deceased alive on March 8th 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE, SIGNED | |
| William Cieplinski M.D. | | | | 3/8/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| William Cieplinski M.D. | | | | Sinai Hospital of Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| BURIAL | 3/9/67 | AITZ CHAIM | BALTIMORE, MARYLAND | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| MAR 10 1967 | Robert E. Taylor, M.D. | SQL LEVINSON & BROS. INC., 6010 REIST., RD. | | | |



VALLEY PEOPLE

AVAILABLE FOR

JOE KIM JIMMY

WILLIAM R. KIM

BIRTH NO. 67 2386

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2386

M.E. CASE NO.

| | | | | | | | |
|---|--|--|--|---|--|--|----------------------------------|
| 1. NAME OF DECEASED (Type or Print) Quentin Dickinson | | | | 2. DATE AND HOUR PRONOUNCED DEAD 3/4/67 12:35 p. m. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 31 City Hospitals | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore Co. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 8209 Harris Ave. | | | |
| 5. SEX male | | 6. RACE white | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | | 8. DATE OF BIRTH Dec 2 1918 | |
| 9. AGE (in years last birthday) 48 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Terminal Mgr. | | 11. BIRTHPLACE (State or foreign country) Penn | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joseph P. Dickinson | | | | 14. MOTHER'S MAIDEN NAME Adda Farrah | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2 | | 16. SOCIAL SECURITY NO. 206-10-9641 | | 17. INFORMANT ADDRESS Family records | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia and necrotizing laryngo- Tracheobronchitis ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Cerebral Injury and Subdural Hematoma. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) factory | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4900 Blk. Boston St. 26-36 | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 1 19 67 ? | | 21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? fell down elevator shaft | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/5/67 | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 3/8/67 | | 23C. NAME of CEMETERY or CREMATORY Gardens of Faith | | 23D. LOCATION (City, town, or county) (State) Balto Co. Md/ | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | 24B. NAME OF REGISTRAR Paul E. Farrah | | 24C. FUNERAL DIRECTOR ADDRESS C. F. EVANS & SON 8802 Harford rd. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2367 | |
|--|----------------------|---|-----------------------------------|---|---|
| BIRTH NO. 67 2367 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) RITZEL, WILLIAM | | | |
| 2. DATE AND HOUR OF DEATH 3/7/67 305 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN Hosp. of Md. | | A. STATE 5-505 Daybreak Terr. #6 B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 53-00 D. STREET ADDRESS (If rural, give location) 5505 Daybreak Terrace | | | |
| 5. SEX MALE | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 1-10-1917 | 9. AGE (In years last birthday) 50 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator | | 10B. KIND OF BUSINESS OR INDUSTRY Baltimore, Transit | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Unknown Ritzel | | 14. MOTHER'S MAIDEN NAME Mary Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W 11 | | 16. SOCIAL SECURITY NO. 216-07-8232 | | 17. INFORMANT ADDRESS Mrs Thelma Ritzel 5505 Daybreak Terr. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) Cancer of liver (B) Cancer of Pancreas (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 2/17/67 19 67 to 3/7/67 19 67 . that (I) was lost saw the deceased alive on 3/7/67 19 67 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE I. Rejaie | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/7/67 | |
| 23C. PHYSICIAN'S NAME (Type) Rejaie | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-10-1967 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith | |
| 24D. LOCATION (City, town, or county) Baltimore, Co. | | (State) Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | 25B. NAME OF REGISTRAR Paul S. Talbot | | 25C. FUNERAL DIRECTOR ADDRESS Logan General Home 7401 Belair Road 36 | |

10/1/68

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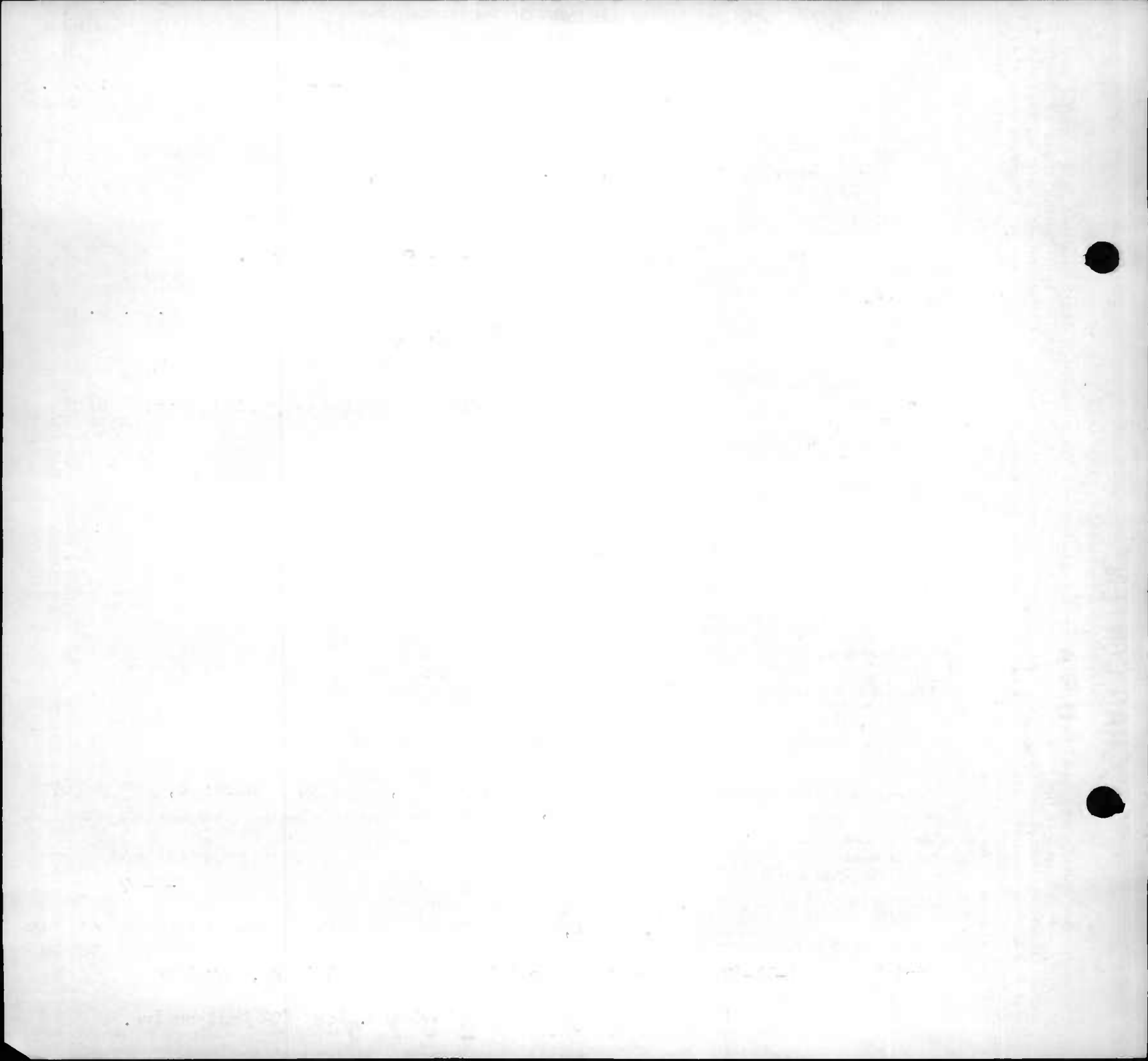
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

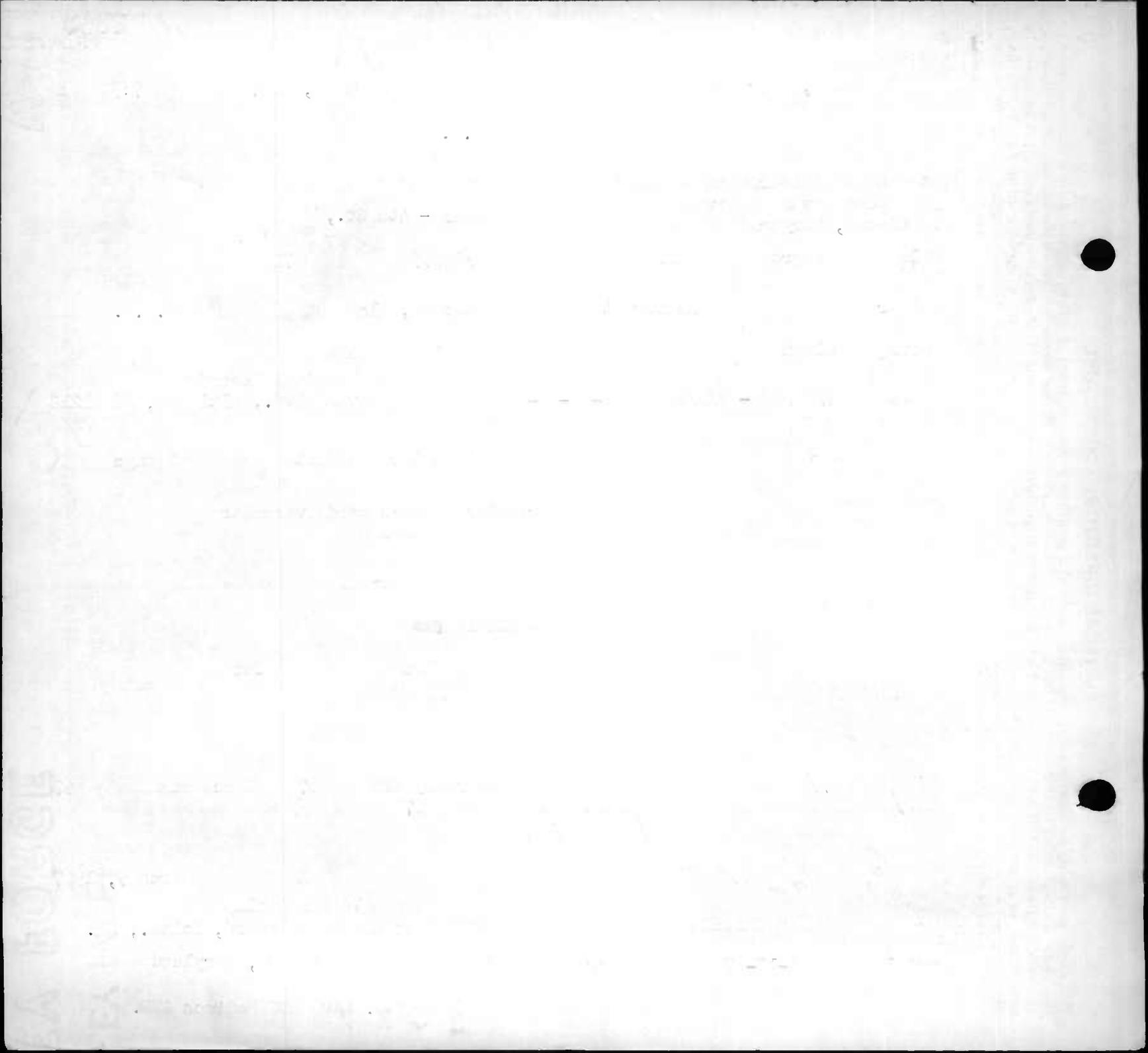
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|---------------|--|-----------------------------------|--|---|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. | | | | |
| BIRTH NO. 67 2368 | | | | | 67 2368 | | | | |
| M.E. CASE NO. A. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Lottie Williams | | | | | 2. DATE AND HOUR OF DEATH 3-8-67 8:30 P. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital, Inc. | | | | | A. STATE B. COUNTY Maryland | | | | |
| 39 | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 15-11 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 3305 Dorchester Road | | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated | 8. DATE OF BIRTH 2-13-09 | 9. AGE (In years lost birthday) 58 yrs. | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME Unknown | | | | | 14. MOTHER'S MAIDEN NAME Annie ? | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Johncie Montgomery (daughter) SAME | | | | |
| 18. CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO Carcinomatosis 3 months | | | | |
| | | | | | (B) DUE TO Ca of Breast 2 1/2 yrs | | | | |
| | | | | | (C) DUE TO | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from February 13, 19 67 to March 8, 19 67, that (I) (we) last saw the deceased alive on March 8, 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE ROLAND T. SMOOT M.D. | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3-9-67 | | |
| 23C. PHYSICIAN'S NAME (Type) Roland T. Smoot, M.D. | | | | | 23D. ADDRESS 3817 Copley Rd., BALTO. 15, MD. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-11-67 | | 24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. 3-10-67 | | | | | 25B. NAME OF REGISTRAR Charles R. Law | | 25C. FUNERAL DIRECTOR ADDRESS 802 Madison Ave. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2369</u> | |
|---|-------------------------|--|------------------------------------|--|---|
| BIRTH NO. <u>67 2369</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>GLENN, George Joseph</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>March 8, 1967</u> <u>7:50</u> a.m. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Veterans Administration Hospital</u> <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u> | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>D.C.</u> B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Washington</u> D. STREET ADDRESS (If rural, give location) <u>1643 - 4th St., NW</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u> | 8. DATE OF BIRTH <u>9/22/95</u> | 9. AGE (In years last birthday) <u>71</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Resturant</u> | | 11. BIRTHPLACE (State or foreign country) <u>Gadsden, Ala</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>George A Glenn</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Margie Ann Kahn</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>9/30/18 - 2/3/19</u> | | | |
| 16. SOCIAL SECURITY NO. <u>382-07-75-67</u> | | 17. INFORMANT <u>VA Hospital Records</u> ADDRESS <u>3900 Loch Raven Blvd., Baltimore, Md 21218</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular accident</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic cardiovascular disease</u> | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Achalasia</u> | | | | | |
| 21A. DATE OF OPERATION <u>2</u> | | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21C. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22. I certify that <u>11</u> (this hospital) attended the deceased from <u>February 28th</u> 19 <u>67</u> to <u>March 8th</u> 19 <u>67</u> , that <u>11</u> (we) last saw the deceased alive on <u>March 8th</u> 19 <u>67</u> and that in <u>11</u> (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (d/d for) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Crile Crisler, M.D.</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>March 9, 1967</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>CRILE CRISLER</u> | | 23D. ADDRESS <u>VA Hospital</u> <u>3900 Loch Raven Boulevard, Balto., Md. 21218</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-13-67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u> | |
| 24D. LOCATION <u>Baltimore, Maryland</u> | | 25A. DATE RECEIVED BY HEALTH DEPT. <u>MAR 10 1967</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Fisher</u> | | 25C. FUNERAL DIRECTOR <u>Charles E. Law</u> ADDRESS <u>802 Madison AVE.</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|--|--|
| BIRTH NO. 67 2370 | | CERTIFICATE OF DEATH | | Registered No. 67 2370 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) ANDREW SMITH | | | 2. DATE AND HOUR OF DEATH 8 MARCH 1967 1310 HOURS | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 33 BALTIMORE, MARYLAND | | | A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-02 D. STREET ADDRESS (If rural, give location) 1819 Baker Street | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9/19/96 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Frank Smith | | | 14. MOTHER'S MAIDEN NAME Mariam | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 812166238 | 17. INFORMANT Mamie Smith 1819 Baker Street | | |
| 18. 334X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) CEREBRAL ARTERIOSCLEROSIS DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH SEVERAL MONTHS |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | trans urethral resection of prostate WAS 4 HOURS POST-OP. TUR-P | | |
| 19A. DATE OF OPERATION 8 MAR 67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BPH | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8 MAR 1967 to 8 MAR 1967 , that (I) (we) last saw the deceased alive on 8 MAR 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE F.B. Hendricks | | | | 23B. DATE SIGNED 8 MAR 67 | |
| 23C. PHYSICIAN'S NAME (Type) FREDERICK B. HENDRICKS | | | 23D. ADDRESS JOHNS HOPKINS HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3-11-67 | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Pk. | 24D. LOCATION (City, town, or county) (State) Arbutus, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | 25B. NAME OF REGISTRAR Robert E. Johnson | 25C. FUNERAL DIRECTOR Kelson Funeral Home-1348 Calhoun St. | | | |

15-10-15

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. | |
|---|---------|--|------------------|--|------------------------------|
| 67 2371 | | CERTIFICATE OF DEATH | | 67 2371 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | MILLER, DOROTHY | | 3/8/67 4 ⁰⁵ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| UNIVERSITY HOSPITAL | | MD BALTIMORE | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1825 N. PAXSON ST | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| F | N | M | 11-7-27 | 38 | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | | | MARYLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| JAMES EDWARD GILES | | MARY TOLIVER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 220 22 4502 | | CHART | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 687X I | | (A) Cerebral Vascular Accident | | 1 1/2 hrs | |
| ANTECEDENT CAUSES | | (B) Hypertensive Epilepsy | | 13 hrs | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Paralytic Ileus | | 4 days | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 4 1/2 | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 3/3/67 | | MULTIPARITY, REPEAT CSECTION | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 28, 1967 to March 8, 1967, that (I) (we) last saw the deceased alive on March 8, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Patrick F. Dougherty, Jr. M.D. | | | | 3/8/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| PATRICK F. DOUGHERTY, JR. M.D. | | | | University Hospital - Balt., Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 3-13-67 | | Mt Auburn Cem. | |
| | | | | Balto. | |
| | | | | Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 10 1967 | | Robert E. Fairbank | | Thurmond S. Oden - Balto. Md. | |

WATER, DRY

CHICKEN, BROWN

WATER, DRY

Control Water (buck)

Light
Tough
Fine

Can be used

2/10/12



Water & Tough

Water & Tough

Water & Tough

X

2/10/12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2372 | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. 67 2372 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Concetta 'Minnie' Guarrera | | | |
| 2. DATE AND HOUR OF DEATH March 9 1967 | | M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital | | A. STATE Maryland B. COUNTY Baltimore Co | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Catonville | | D. STREET ADDRESS (If rural, give location) 715 Crosby Road | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED Widowed | 8. DATE OF BIRTH Aug 24 1892 | 9. AGE (In years lost birthday) 74 | If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress | | 10B. KIND OF BUSINESS OR INDUSTRY Tailoring | | 11. BIRTHPLACE (State or foreign country) Italy | |
| 12. CITIZEN OF WHAT COUNTRY? Italy | | 13. FATHER'S NAME Arnello Guarrera | | 14. MOTHER'S MAIDEN NAME Coloutta | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 212 03 9080 | | 17. INFORMANT Richard Guarrera 302 S Woodyear St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) arteriosclerotic heart disease | | CAUSE OF DEATH (A) DUE TO myocardial damage (B) DUE TO heart failure (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-15-49 19 to 3-9-67 19, that (I) (we) last saw the deceased alive on 3-2-67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. Gimbel | | | | 23B. DATE SIGNED 3-10-67 | |
| 23C. PHYSICIAN'S NAME (Type) HARRY S. GIMBEL | | | | 23D. ADDRESS 4605 Edmonda Ave (29) Wd. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-13-67 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Thomas J. Kenny Inc 1600 Hollins St | | | |

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Handwritten text, possibly a signature or name, located in the lower left section of the page.

Handwritten text, possibly a signature or name, located in the lower right section of the page.

Released on approval for use in the Baltimore City Health Department
for approval of Medical Examiner
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2373 | |
|--|--|---|--|---|--|
| BIRTH NO. 67 2373 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. 67 2373 | | | | 1. NAME OF DECEASED (Type or Print) William H. Butler | |
| 2. DATE AND HOUR OF DEATH March 9, 1967 515 A.M. | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hosp. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY BALTIMORE | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | D. STREET ADDRESS (If rural, give location) 2522 W. Cold Spring Lane | |
| 5. SEX MALE | | 6. RACE C. | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | |
| 8. DATE OF BIRTH 10-6-99 | | 9. AGE (In years last birthday) 67 | | 10. CITIZEN OF WHAT COUNTRY? U.S. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. FATHER'S NAME William Butler | | 13. MOTHER'S MAIDEN NAME Rosie Holmes | | 14. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | |
| 15. SOCIAL SECURITY NO. 27-5-1877 | | 16. INFORMANT C. Boetsch R.M.D. Univ. Hospital | | ADDRESS | |
| 17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Dissecting Aneurysm OF THORACIC AORTA | | 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. DATE OF OPERATION 3-8-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Dissecting Aneurysm | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-28 1967 to 3-9 1967, that (I) (we) last saw the deceased alive on 3-9- 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Carlos Boetsch | | | | 23B. DATE SIGNED 3-9-67 | |
| 23C. PHYSICIAN'S NAME (Type) Carlos Boetsch | | | | 23D. ADDRESS M.D. University Hospital BALMO | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-13-67 | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cmt | |
| 24D. LOCATION (City, town, or county) Balto | | 24E. STATE Md | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | |
| 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Harry O Wilson | | ADDRESS 1400 Grantley St | |

1
H-560

67 2371

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2371

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CORNELIA

HENRY

2. DATE AND HOUR PRONOUNCED DEAD

March 8, 1967

6:55 P.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

202 N. Fremont Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

202 N. Fremont Avenue

18-01
apt 3

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

May 2-1897

9. AGE (In years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Charlotte NC

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Moon

14. MOTHER'S MAIDEN NAME

Mary Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

Elisha Perry

ADDRESS

Samuel

18.

581.0 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cirrhosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Hypertensive Cardiovascular Disease.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

3/9/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-13-67

23C. NAME OF CEMETERY or CREMATORY

Balto Nat Cat

23D. LOCATION

Balto

(City, town, or county) (State)

md

24A. DATE REC'D BY HEALTH DEPT.

MAR 10 1967

24B. NAME OF REGISTRAR

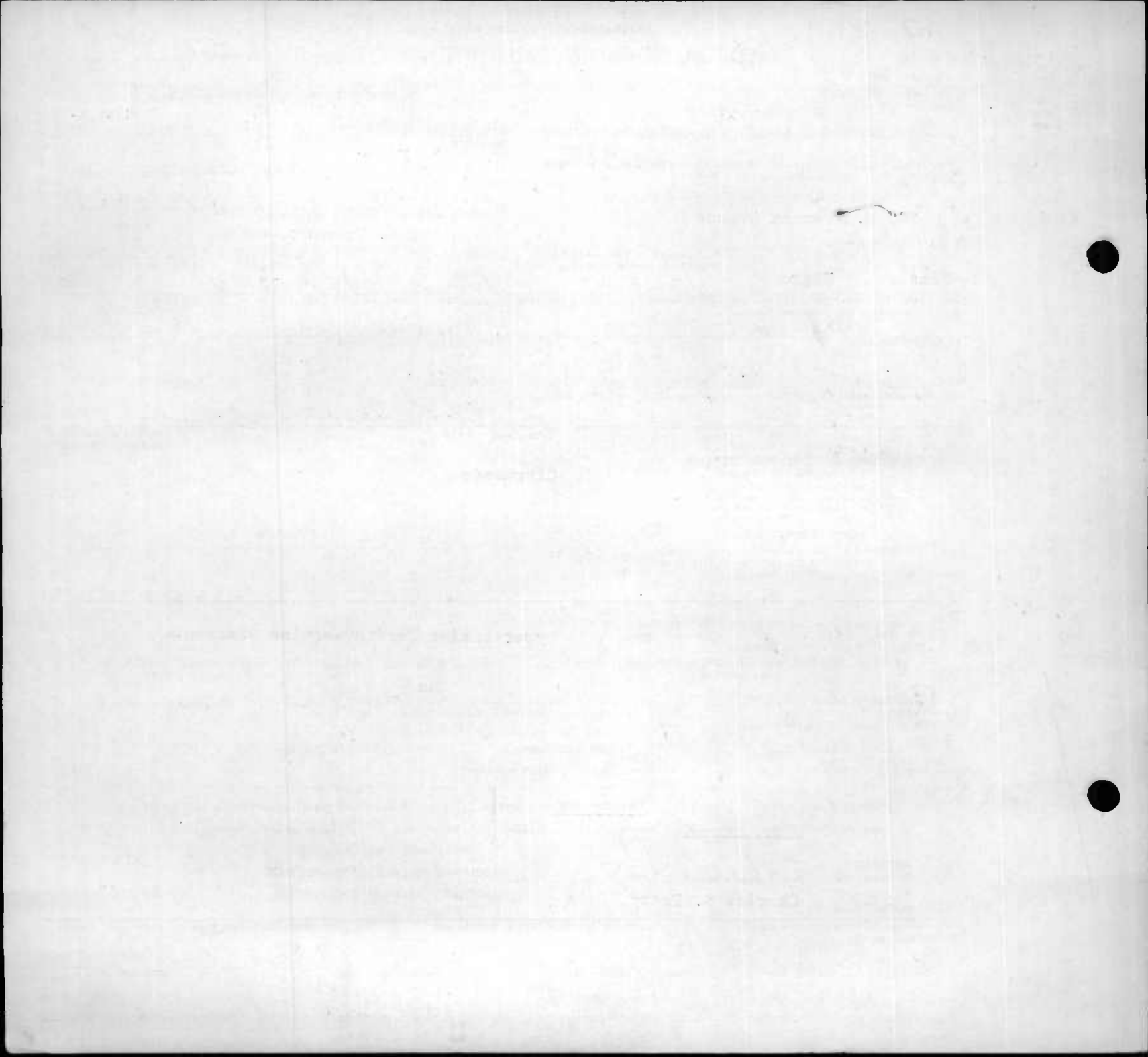
Robert E. Jackson

24C. FUNERAL DIRECTOR

Shoy Wilson

ADDRESS

1020 Brantley Ave



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES C. BRYANT

2. DATE AND HOUR PRONOUNCED DEAD

3-5-67

4:30 PM M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6524 Fait Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Divorced

8. DATE OF BIRTH

April 10, 1910

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Steelworker

10B. KIND OF BUSINESS OR INDUSTRY

Bethlehem Steel Co. Nelson Co. Va.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Wm. Jesoph Bryant

14. MOTHER'S MAIDEN NAME

Maggie Jennings

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

ADDRESS

Myrtle B. Taylor 1335 24th St. Newport News, Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Carbon monoxide poisoning - associated

XXXXX

with smoke and soot - incidental to
conflagration

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

House

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

6524 Fait Avenue 21224

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3 5 '67 PM

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Burned in house fire

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

WERNER U. SPITZ, M.D.

M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

3-6-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/9/67

23C. NAME of CEMETERY or CREMATORY

Prospect Hill Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks, Inc. 1217 St. Paul St.

WALTER PIERCE

Walter Pierce

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. 67 2376 | |
|--|--|--|--|--|--|
| BIRTH NO. 67 2376 | | M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH Mar. 8, 1967 6: 55 P M. | |
| 1. NAME OF DECEASED (Type or Print) Gordon Ray | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st St. | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore | | 5. SEX M RACE W 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | | | |
| 8. CITY OR TOWN (If outside city limits, write RURAL and give township) Cockeysville | | 9. AGE (In years, last birthday) 64 | | | |
| 10. STREET ADDRESS (If rural, give location) 301 Lord Byron Drive Lane | | 11. BIRTHPLACE (State or foreign country) Ind. | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John Baker Ray | | | |
| 14. MOTHER'S MAIDEN NAME Georgia-Roseberry Roseberry | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USN 1919-1921 | | | |
| 16. SOCIAL SECURITY NO. 467-14-4722 | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Congestive failure Arteriosclerotic cardiovascular disease Nutritional cirrhosis INTERVAL BETWEEN ONSET AND DEATH mos. yrs. yrs. | | | | | 19. DATE OF OPERATION 2 |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) yes |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from Mar. 6 1967, to Mar. 8 1967, that (I) (we) last saw the deceased alive on Mar. 8 1967 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Michael E. Pelczar M.D. | | | | | 23B. DATE SIGNED 3/9/67 |
| 23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, SA Surgeon (R) M.D. | | | | | 23D. ADDRESS US PHS Hospital, Balto, Md. |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Mar. 11, 1967 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Finkbeiner | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland (4) | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. | |
|---|--------------|---|---|---|---|---|-------------------------------------|
| 67 2377 | | | | | | 67 2377 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Walter Egbert | | | | March 7, 1967 9:50 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st St. | | | | A. STATE Va. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Mc Lean D. STREET ADDRESS (If rural, give location) 6812 Wemberly Way | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH 8/3/80 | 9. AGE (In years last birthday) 86 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | 11. BIRTHPLACE (State or foreign country) Ill. | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Lewis Egbert | | | 14. MOTHER'S MAIDEN NAME Frances Bryan | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 152-14-7569 | | 17. INFORMANT Records- US PHS Hospital, Balto, Md. | | |
| 18. 204.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) LOBAR PNEUMONIA (A) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH DAYS | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE MYELOGENOUS LEUKEMIA (C) DUE TO | | | | ? | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 14 19 67 to Mar. 7 19 67, that (I) (we) last saw the deceased alive on Mar. 7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Michael E. Pelczar M.D. | | | | 23B. DATE SIGNED 3/7/67 | | 23C. PHYSICIAN'S NAME (Type) Michael E. Pelczar, SA Surgeon (in R) M.D. | |
| 23D. ADDRESS US PHS Hospital, Balto, Md. | | | | 24. BURIAL CREMATION, REMOVAL (Specify) CREMATION 3-9-67 | | | |
| 24B. DATE 3-9-67 | | 24C. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE RECEIVED BY HEALTH DEPT. MAR 10 1967 | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Cook-Brooks Inc. | | 25D. ADDRESS 1217 St. Paul St. | | 25E. DATE OF REGISTRATION MAR 10 1967 | |

LOBAR PNEUMONIA
DAYS

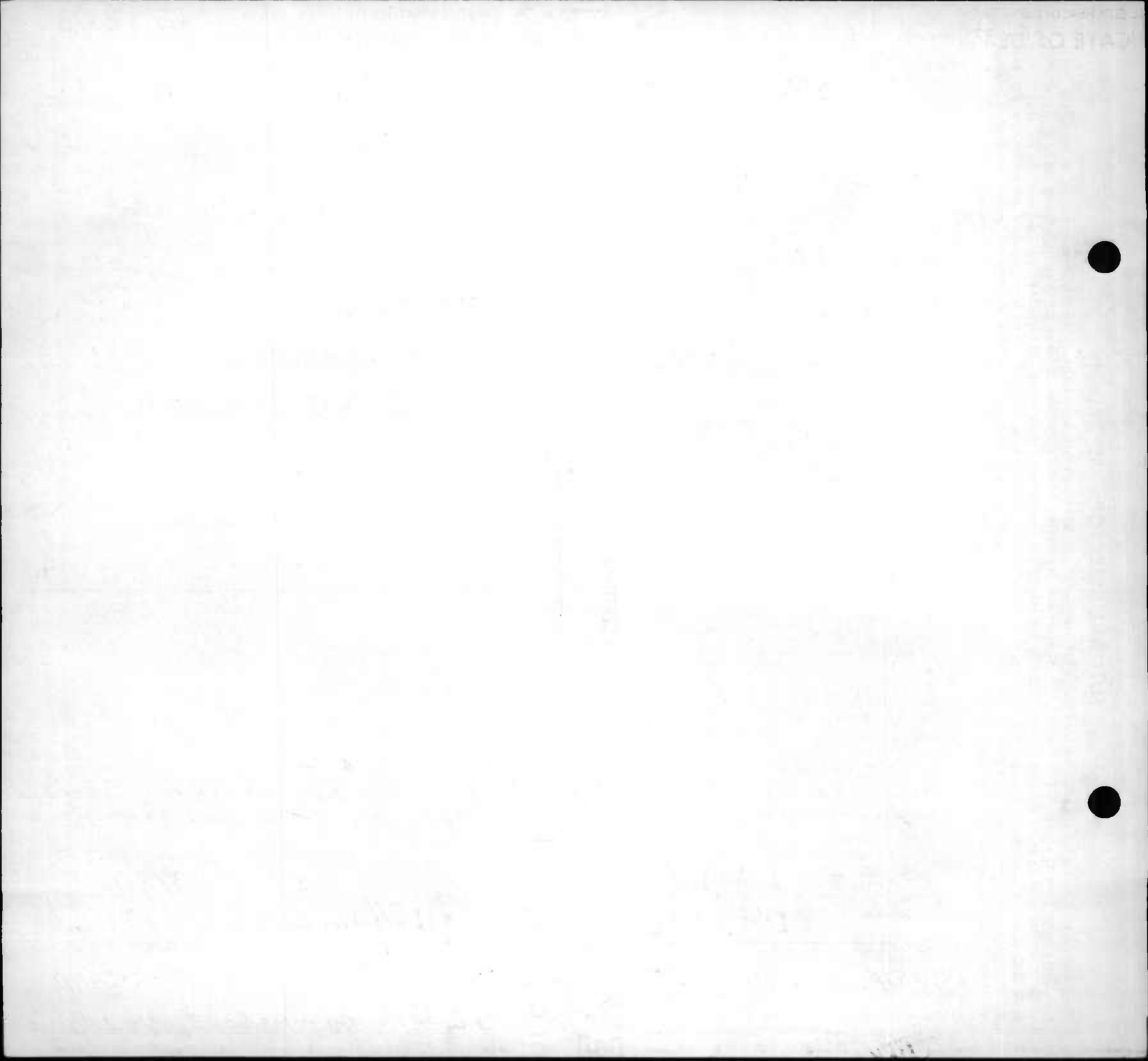
ACUTE MYELOGENOUS
LEUKEMIA

Michael E. Pellegrini

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|-----------------------------|--|---|
| BIRTH NO. 67 2378 | | CITY HEALTH DEPARTMENT | | Registered No. 67 2378 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) KREBS, EDWARD | | 2. DATE AND HOUR OF DEATH 3/8/67 12:15 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital of Maryland | | A. STATE Maryland | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-47 | | | |
| | | D. STREET ADDRESS (If rural, give location) 3025 Windsor A.V. | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 3-19-78 | 9. AGE (In years last birthday) 88 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME MICHAEL KREBS | | 14. MOTHER'S MAIDEN NAME ? LEWBECKER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT CHART LUTHERAN HOSPITAL | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pneumonitis | | CAUSE OF DEATH Fracture of right femur | | INTERVAL BETWEEN ONSET AND DEATH 2/14/67-3/18/67 | |
| 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| 18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home. | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3023 Windsor Ave 15-47 | |
| 21D. TIME OF INJURY (APPROX.) 2/14/67 pm | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Fall on floor. | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/14/1967 to 3/18/1967, that (I) (we) last saw the deceased alive on 3/7/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE I. Rejaie | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/8/67 | |
| 23C. PHYSICIAN'S NAME (Type) IRAJ. REJAIE | | 23D. ADDRESS Lutheran Hospital of Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/11/67 | | 24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM. | |
| 24D. LOCATION BALTO. MARYLAND | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | 25B. NAME OF REGISTRAR R. O. B. E. E. E. | | 25C. FUNERAL DIRECTOR WEBER FUNERAL HOME 5311 EDMONDSON AVE | |



5-600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 2379

BIRTH NO.

67 2379

M.E. CASE NO.

SCHWIER, MILDRED S.

1. NAME OF DECEASED
(Type or Print)

Schwier, Mildred

2. DATE AND HOUR OF DEATH

3/8/67

330 P

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

48

Maryland General
Hospital4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

21213 26-03

D. STREET ADDRESS (If rural, give location)

3061 Mayfield Ave.

5. SEX

Female

6. RACE

Caucasian

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10/18/02

9. AGE (In years
last birthday)

64

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore MD.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Conrad F. Schwier

14. MOTHER'S MAIDEN NAME

Rosa Stoltz

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

none

16. SOCIAL
SECURITY NO.

216-03-2809

17. INFORMANT

293

ADDRESS

admission record

18.

170X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C)

Carcinomatosis
left Breast carcinoma

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2-26/67

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

CA Breast

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

NONE

21E. INJURY OCCURRED
While At Work ☐ Not While
At Work ☐21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/2/67 to 3/8/67
that (I) (we) last saw the deceased alive on 3/8/67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) did (did not) view the body after death.

23A. SIGNATURE

Fred R. Eilber

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

3/8/67

23C. PHYSICIAN'S
NAME (Type)

FRED R. EILBER

M.D.

23D. ADDRESS

Maryland General Hosp

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/11/67

24C. NAME of CEMETERY or CREMATORY

Parkwood Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAR 10 1967

25B. NAME OF REGISTRAR

ROBERT E. FARRER

25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto. Md. 21214

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

9-27

10/1/01

10/1/01

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10/1/01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2380</u> | |
|--|-------------------------|---|---------------------------------|--|---|
| BIRTH NO. <u>67 2380</u> | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Walter Jeffers (Jefferies)</u> | | | | 3-9-67 3:05 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</u> | | | | A. STATE <u>Maryland</u> 8. COUNTY | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore, 13-03</u> | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>2434 Madison Avenue</u> | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <u>1897</u> | 9. AGE (In years last birthday) <u>70 yrs.</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>087-09-9995-A</u> | | 11. BIRTHPLACE (State or foreign country) <u>Wake Co. North Carolina</u> | |
| 13. FATHER'S NAME <u>Levy Jefferies</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 14. MOTHER'S MAIDEN NAME <u>Mollie Bradshaw</u> | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT <u>Kaiser, Miller</u> | |
| 18. <u>420.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>C.V.A.; Cerebral arteriosclerosis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>A.S.H.D.</u> <u>Epilepsy</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>SAME</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March 7, 1967</u> to <u>March 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 9, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | | | 23B. DATE SIGNED <u>2-9-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>CARRILLO</u> | | | | 23D. ADDRESS <u>Provident Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-12-67</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>St. Mary Freewill Cem. Apex, North Carolina</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <u>Morton & Dett F.H.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>1701 Laurens St.</u> | |

MAR 10 1967

STANLEY
GARLAND

Robert Lloyd

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|----------------------|---|------------------------------|--|---|
| BIRTH NO. 67 2381 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2381 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WERNER, ELIZABETH CATHERINE | | 2. DATE AND HOUR OF DEATH 3-7-67 2:15AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE 29 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE 29, MD. | | D. STREET ADDRESS (If rural, give location) 312 MT. OLIVE LANE | | 20-06 | |
| 5. SEX FEMALE | 6. RACE CAUCASION | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 09-10-94 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) NEW YORK | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JOHN XXXXXX Lorch DEC'D | | 14. MOTHER'S MAIDEN NAME CATHERINE Martinia DEC'D | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-24-4711 | | 17. INFORMANT ADDRESS AVES # 29 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443X-260X Disease or condition directly leading to death | | CAUSE OF DEATH (A) DUE TO intracerebral hemorrhage (B) DUE TO hypertension (C) DUE TO arteriosclerotic cardiovascular disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus | | 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) N | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 5 19 67 to MARCH 7 19 67, that (I) (we) last saw the deceased alive on MARCH 7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE George S. Bohannon M.D. | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-10-67 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State) 3801 Frederick Ave., Balto., Md | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | 25D. ADDRESS | | | |

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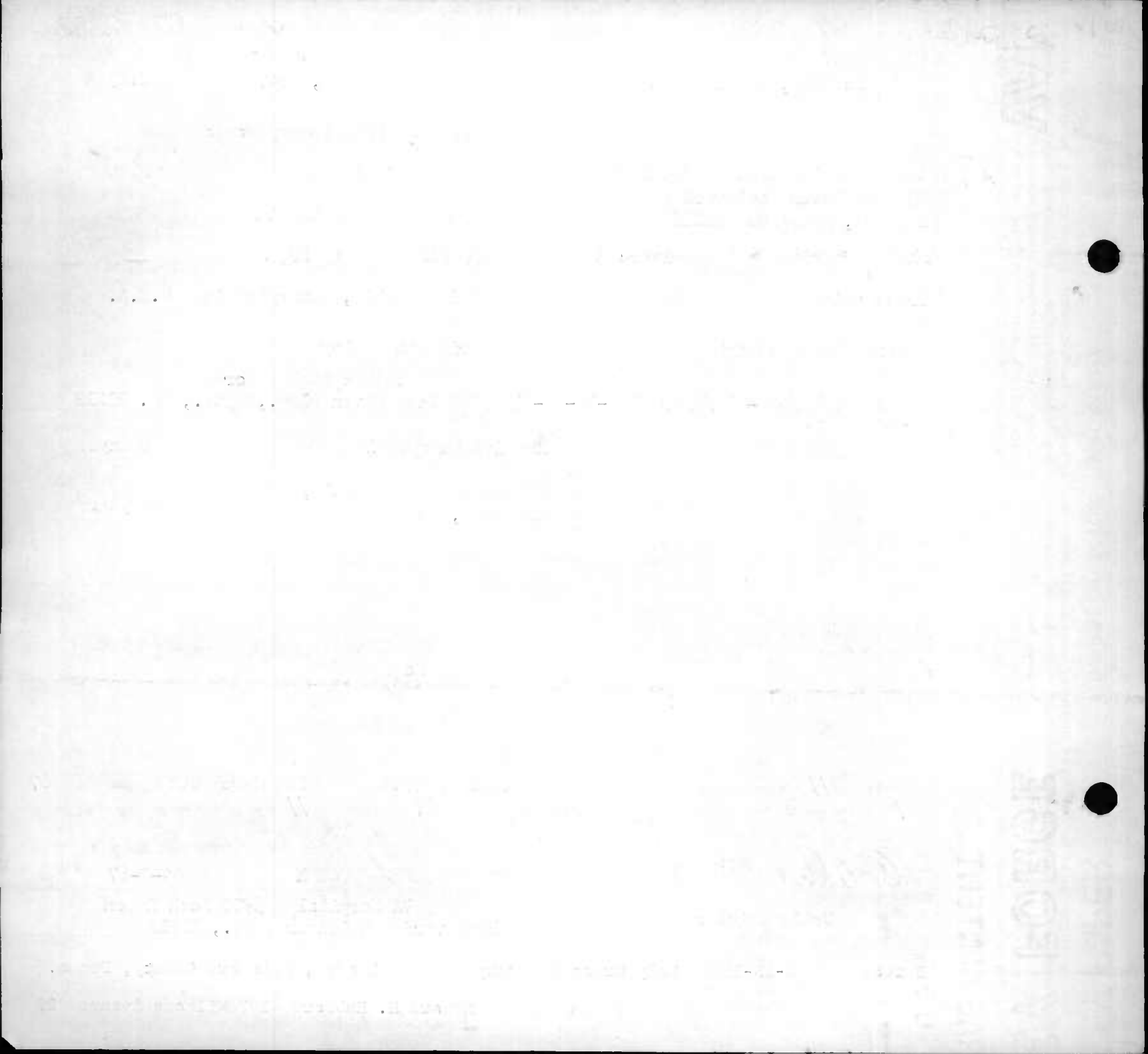
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

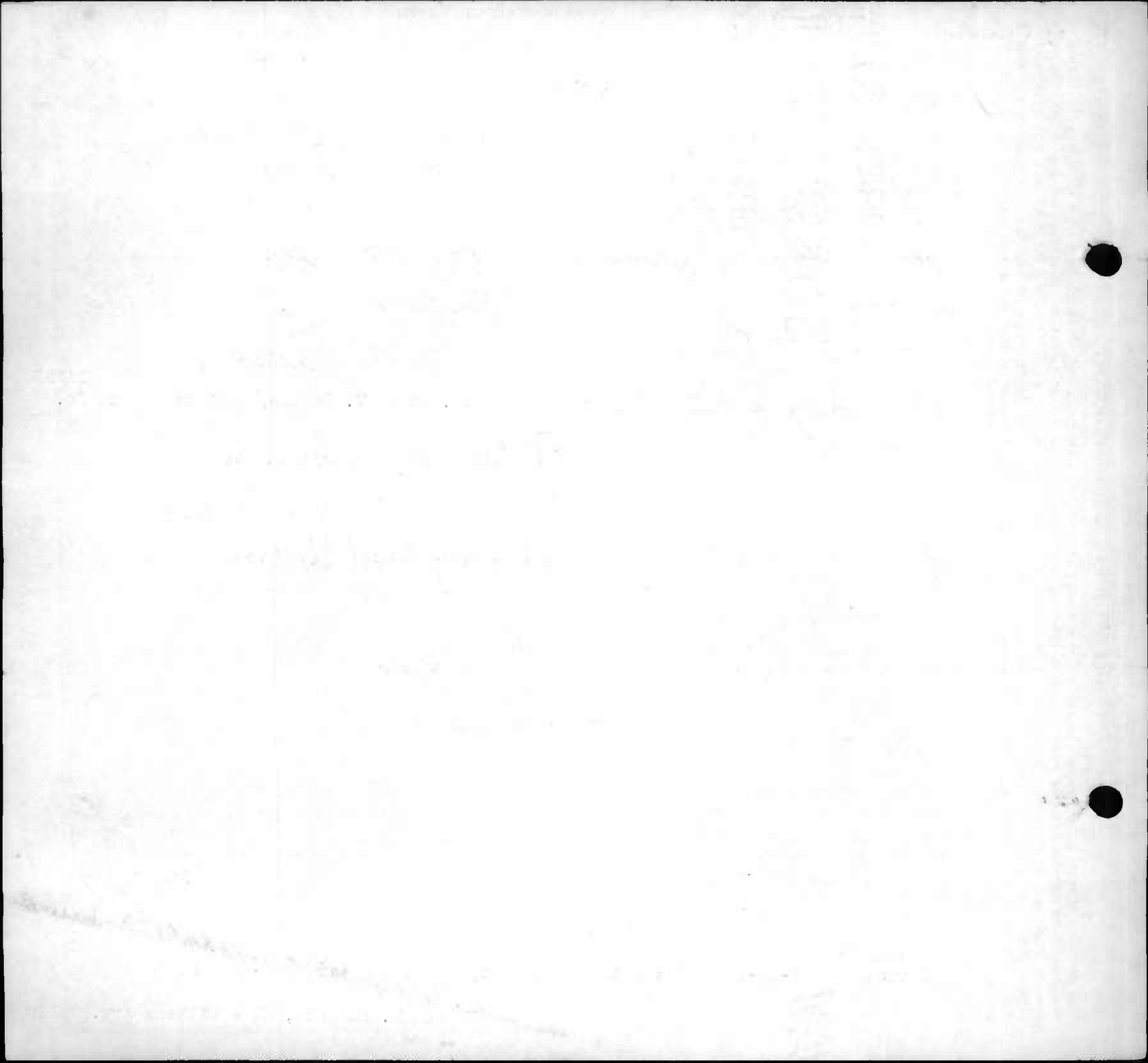
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|--|-------------------------|---|--|---|---|
| BIRTH NO. 67 2382 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2382 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) McVEIGH, WILLIAM BERNARD | | | March 8, 1967 10:23 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Pennsylvania B. COUNTY Philadelphia | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Philadelphia V-35 | | |
| D. STREET ADDRESS (If rural, give location) 3225 S Broad Street | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH 3/9/12 | 9. AGE (In years last birthday) 55 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10B. KIND OF BUSINESS OR INDUSTRY Unknown | 11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Edward James McVeigh | | | 14. MOTHER'S MAIDEN NAME Bridgett Hanley | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 9/29/42 - 10/4/45 | | 16. SOCIAL SECURITY NO. 182-18-81-07 | 17. INFORMANT VA Hospital Records | | |
| | | ADDRESS 3900 Loch Raven Blvd., Balto., Md. 21218 | | | |
| 18. 002.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Massive hemoptysis | | | INTERVAL BETWEEN ONSET AND DEATH 6 days | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary tuberculosis, far advanced, active | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that 1/1 (this hospital) attended the deceased from January 27th 19 66 to March 8th 19 67 , that 1/1 (we) last saw the deceased alive on March 8th 19 67 and that in 1/1 (our) opinion death occurred on the date and hour and from the causes stated above. 1/1 (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Crile Crisler, M.D. | | | | 23B. DATE SIGNED 3-8-67 | |
| 23C. PHYSICIAN'S NAME (Type) Crile Crisler | | 23D. ADDRESS VA Hospital 3900 Loch Raven Boulevard Baltimore, Md., 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-13-1967 | | 24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery | |
| 24D. LOCATION Yeadon, Delaware County, Penna. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | 25B. NAME OF REGISTRAR ORCUTT E. Johnson | | 25C. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Avenue 29 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|---------------------|---|-----------------------------------|--|---|
| BIRTH NO. 67 2383 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2383 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>RAVEIO, SAMUEL, Leo</i> | | 2. DATE AND HOUR OF DEATH <i>12.40 A.M. 3/9/67</i> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore Co.</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Franklin Square Hosp 100 N. Calhoun St.</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>4402 Baltimore St.</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>1-9-87</i> | 9. AGE (In years last birthday) <i>80</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore MD.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>August RAVEIO</i> | | 14. MOTHER'S MAIDEN NAME <i>ROSE ROMA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes ARMY WWI 216-05650</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS 21227 <i>Mrs. Ethel V. Raveio, 4402 Baltimore St.</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.) <i>Pulmonary tuberculosis</i> | | CAUSE OF DEATH (A) DUE TO <i>complicating hyper tension</i> (B) DUE TO <i>coronary heart disease</i> (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>At home</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>At home</i> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3/8</i> 19 <i>67</i> to <i>3/9</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3/9</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Raymundo S. Magno</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>3-9-67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>RAYMUNDO S. MAGNO</i> | | 23D. ADDRESS <i>FRANKLIN SQUARE HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3-13-67</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Howard County, Maryland</i> | | | | | |
| 25A. DATE RECEIVED BY HEALTH DEPT. <i>MAR 10 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Jackson</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2384 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2384 | |
|--|--|---|--|--|--|--|--|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Ada F. Horstman | | | | March 9, 1967 6 ¹⁰ P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Wesley Home, Inc. 2211 West Rogers Avenue | | | | A. STATE Maryland B. COUNTY Baltimore | | | |
| 5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | | | 8. DATE OF BIRTH June 14, 1887 9. AGE (In years last birthday) 79 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 11. BIRTHPLACE (State or foreign country) Fairmount, Md. | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME John S. Ford | | | | 14. MOTHER'S MAIDEN NAME Elizabeth J. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 215-07-5490 | | | |
| 17. INFORMANT The Wesley Home, Inc. same address | | | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.141153.8 Myocardial infarction | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) Arteriosclerotic cardiovascular disease (B) Disease (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 20 Feb + 14 Mar 66 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma colon - recurrence | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9 November 1966 to 10 March 1967 , that (I) was last saw the deceased alive on 7 March 1967 and that in (my) last opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John W. Barnaby | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 10 Mar 67 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN W BARNABY | | | | 23D. ADDRESS 1531 E North Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/13/1967 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | 25B. NAME OF REGISTRAR Reg. E. F. Adams | | 25C. FUNERAL DIRECTOR Wm. F. Fickner & Sons | | ADDRESS Baltimore, Md. North Ave. | |

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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 2385 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2385

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) HERBERT BEVERLY 2. DATE AND HOUR PRONOUNCED DEAD 3-7-67 9:35 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

517 N. Carey Street - Amb. Crew #4

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

517 N. Carey Street 21223

5. SEX Male 6. RACE Colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWER 8. DATE OF BIRTH ? 9. AGE (In years last birthday) 52 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 11. BIRTHPLACE (State or foreign country) Y.A. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ? 14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 17. INFORMANT Address Mahel Bagwell 1109 Somerset St

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease DUE TO

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

DATE SIGNED

3-7-67

23A. BURIAL CREMATION, REMOVAL (Specify) 23B. DATE 3/11/67 23C. NAME OF CEMETERY or CREMATORY MT. CALVARY 23D. LOCATION (City, town or county) (State) A.A. COUNTY - MD.

24A. DATE REC'D BY HEALTH DEPT. 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR ADDRESS

MAR 10 1967

WALLINGFORD

BY

WILLIAM

[Signature]

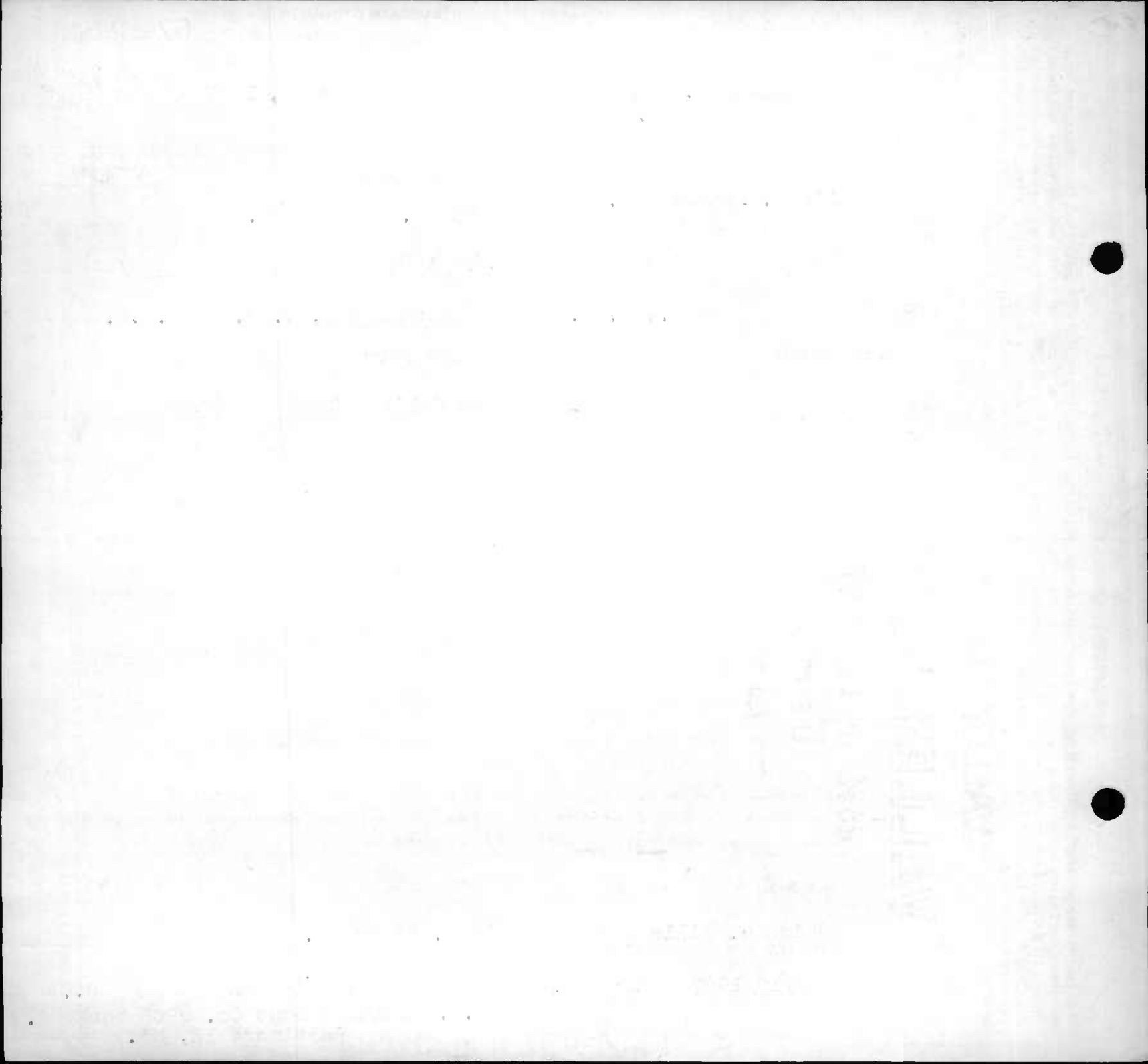
Slater M. R. Quay

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

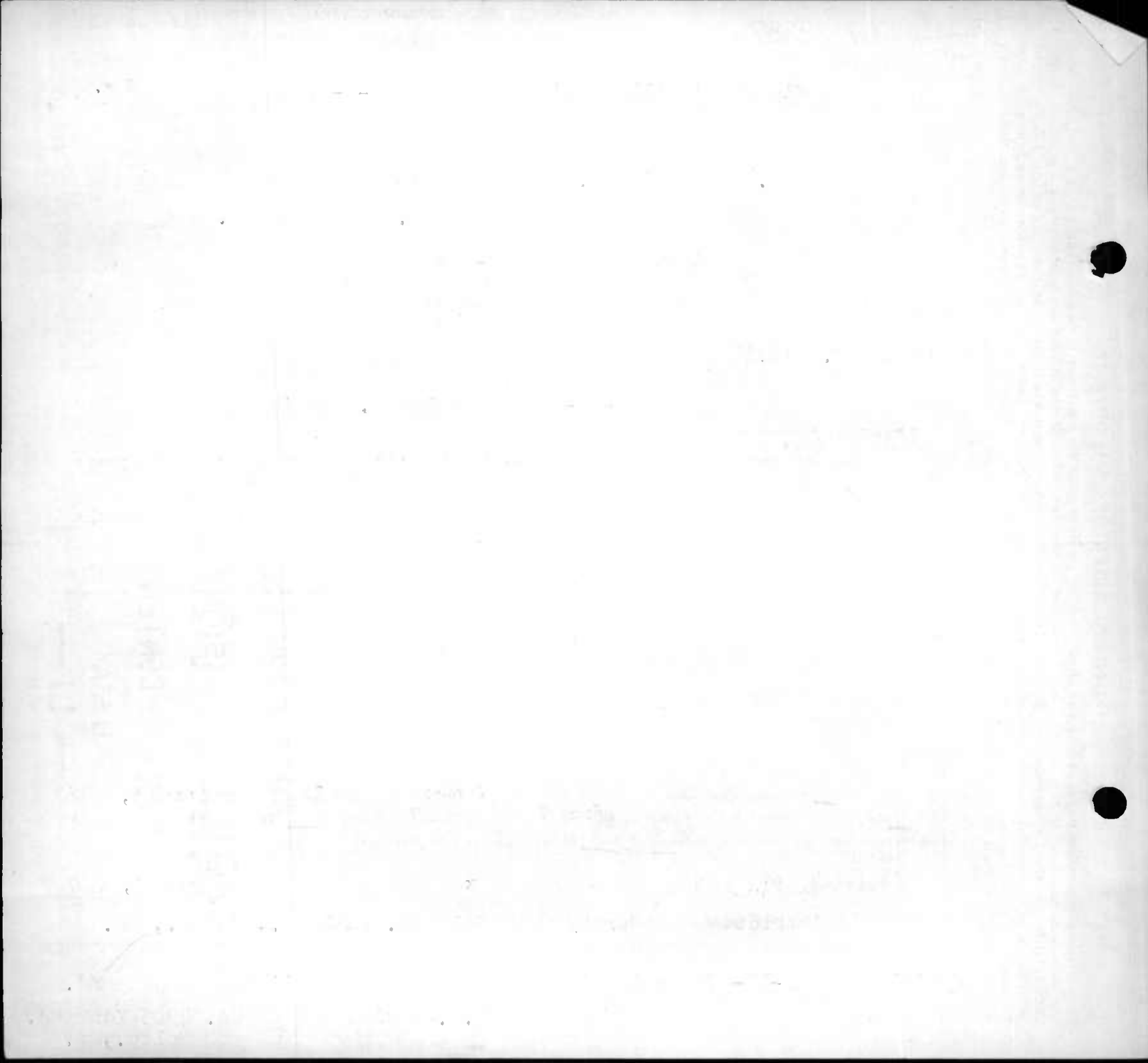
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2386 | |
|--|------------------|---|-----------------------------------|--|---|
| BIRTH NO. 67 2386 | | CERTIFICATE OF DEATH | | DATE AND HOUR OF DEATH MARCH 8, 1967 435 P.M. | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) William F. Stead | | 2. DATE AND HOUR OF DEATH | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 232 W. Lanvale St. | | D. STREET ADDRESS (If rural, give location) 232 W. Lanvale St. | | E. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8/29/1884 | 9. AGE (In years last birthday) 82 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor | | 10B. KIND OF BUSINESS OR INDUSTRY Trinity College Wash., D. C. | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Robert Stead | | 14. MOTHER'S MAIDEN NAME Mary Force | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 596-48-9626 | | 17. INFORMANT Dom Julian Stead ADDRESS (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Bronchial Pneumonia | | CAUSE OF DEATH (A) DUE TO Bronchial Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Emphysema. Myocarditis | | 20 years | |
| | | (C) Arteriosclerosis | | 2 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1960 to MAR 8 1967 that (I) (we) last saw the deceased alive on March 8 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ralph G. Hills | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Mar 9, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) Ralph G. Hills | | 23D. ADDRESS 18 E. Eager St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/10/1967 | | 24C. NAME OF CEMETERY or CREMATORY Oak Hill | |
| 24D. LOCATION (City, town, or county) Washington D.C. | | 24E. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | 24F. ADDRESS 4905 York Rd. Baltimore 12, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

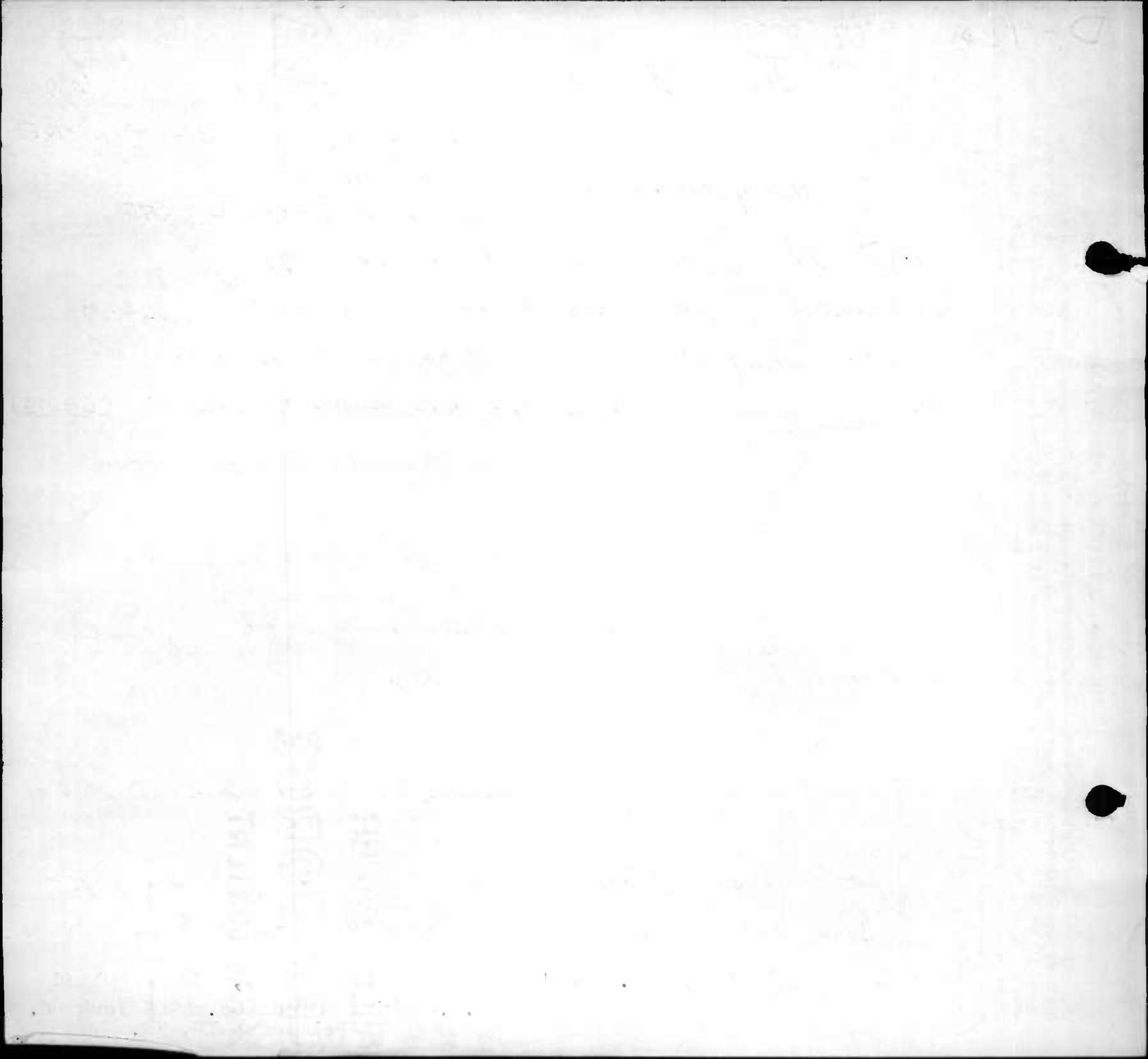
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 2387 | |
|---|--------------|---|--|--|---|
| BIRTH NO. 67 2387 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Blanche O'Neill Curtis | | | 3-9-67 | | 8-a. M. |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 203 E. Highfield Rd. 00 | | | A. STATE Maryland | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 12-01 | | |
| D. STREET ADDRESS (If rural, give location) 203 E. Highfield Rd. | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 4-27-1880 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME William F. O'Neil | | | 14. MOTHER'S MAIDEN NAME Louise Hunt | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 220-44-7358 | 17. INFORMANT Franklin O. Curtis | | ADDRESS Above |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) arteriosclerotic cardiovascular disease senile malnutrition | | | INTERVAL BETWEEN ONSET AND DEATH 20 years 4 months | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 19 38 to March 9, 1967, that (I) (we) last saw the deceased alive on March 7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charlotte McCarthy | | | | 23B. DATE SIGNED March 9, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) Charlotte McCarthy | | | 23D. ADDRESS 2919 St. Paul St., Balto., Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-11-67 | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge | |
| | | | | 24D. LOCATION (City, town, or county) (State) Pikesville Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | 25B. NAME OF REGISTRAR Robert E. Edley | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. | |



FUNERAL DIRECTOR: IMPORTANT

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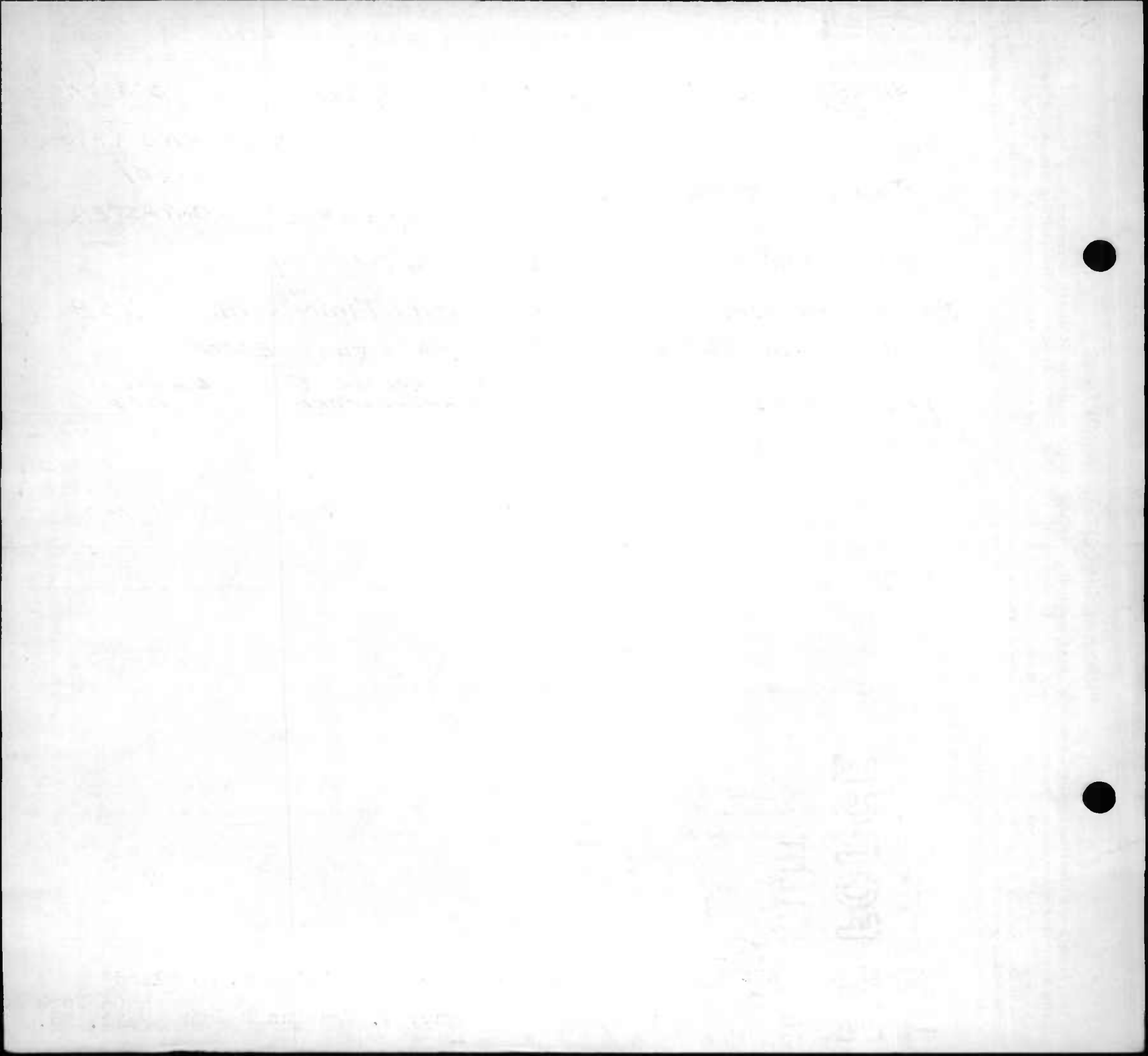
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 2388 | |
|--|--|----------------------------|--|--|--|--|--|---|--|--|--|
| BIRTH NO. 67 2388 | | M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) JOHN THOMAS DALTON | | | | | | 2. DATE AND HOUR OF DEATH 3/9/67 6 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital | | | | | | A. STATE MARYLAND B. COUNTY BALTIMORE | | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) 6401 N. CHARLES ST. | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 1-6-'96 | | 9. AGE (In years last birthday) 71 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARETAKER | | | | 10B. KIND OF BUSINESS OR INDUSTRY VILLA REGINA | | 11. BIRTHPLACE (State or foreign country) MD. BALTIMORE COUNTY | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOSEPH DALTON | | | | | | 14. MOTHER'S MAIDEN NAME MARGARET LYNCH | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 212-32-1747 | | 17. INFORMANT MRS. GLADYS E. DALTON (SAME) | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 420.14260X | | | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | | | (A) Acute Myocardial Infarction | | | | Hours | |
| ANTECEDENT CAUSES | | | | | | (B) DUE TO | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (C) Arteriosclerotic Cardiovascular et Dem | | | | Years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | Broncho pneumonia above knee amputation Diabetes mellitus | | | | Years | |
| 19A. DATE OF OPERATION February 1967 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from January 9 1967 to March 8 1967 , that (I) (we) last saw the deceased alive on March 7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE John Gary Green M.D. | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED March 9, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN GARY GREEN M.D. | | | | | | | | 23D. ADDRESS MERCY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/11/1967 | | 24C. NAME OF CEMETERY or CREMATORY St. John's | | | | 24D. LOCATION (City, town, or county) (State) Long Green, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Baltimore 12, Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

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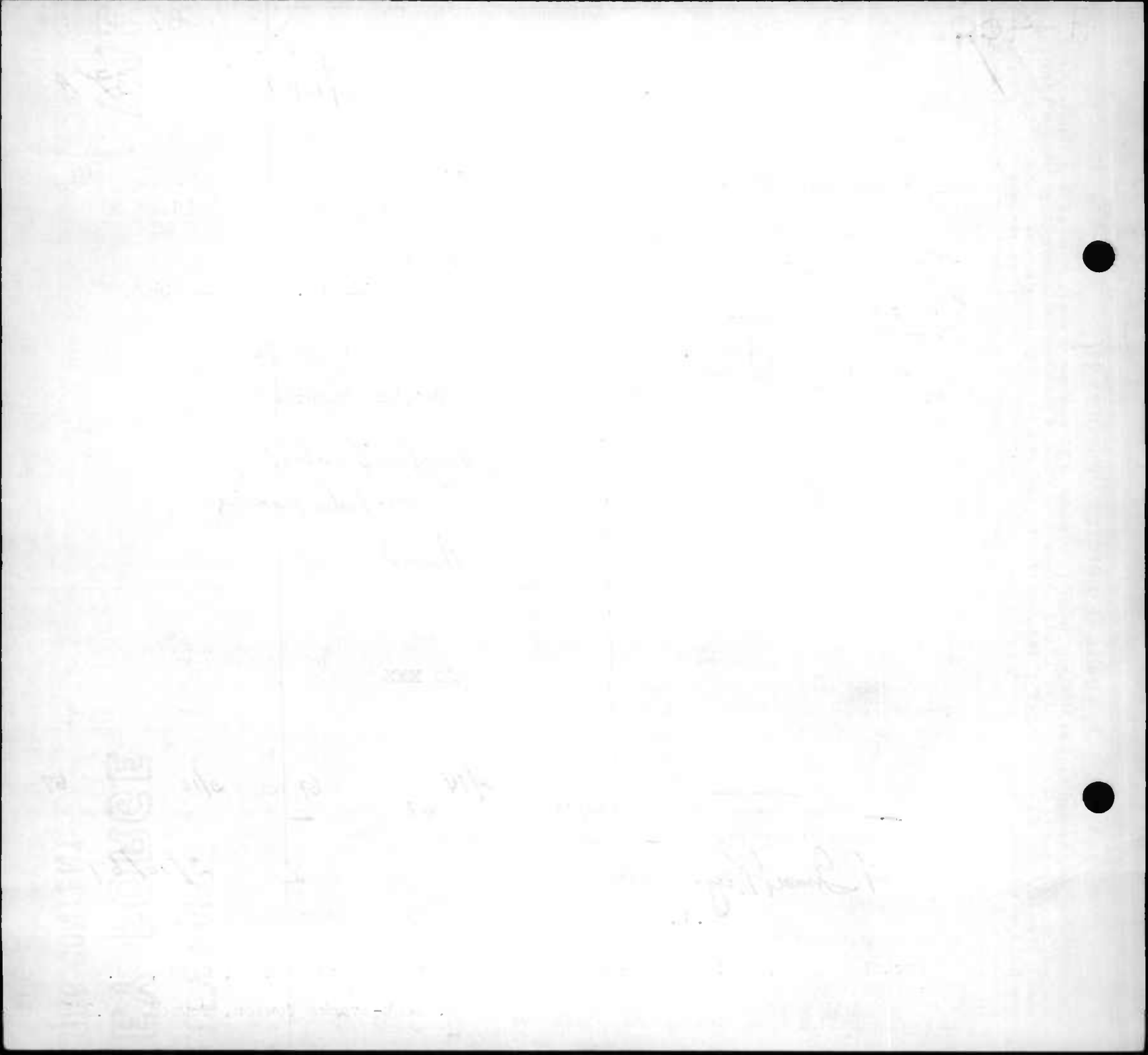
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2389 | |
|--|--|---|--|---|--|
| BIRTH NO. 67 2389 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) SHACKELFORD JR, WILLIAM T. | | | | 3/9/67 3:30 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS Hospital | | | | A. STATE MARYLAND | |
| | | | | B. COUNTY TALBOT | |
| 5. SEX MALE | | | | 6. RACE White | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | | | 8. DATE OF BIRTH 04/12/92 | |
| 9. AGE (In years last birthday) 74 | | | | 10. BIRTHPLACE (State or foreign country) BALTIMORE, MD | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME WILLIAM THOMAS SHACKELFORD | | | | 14. MOTHER'S MAIDEN NAME RACHEAL ESTER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI | | | | 16. SOCIAL SECURITY NO. 020-01-09 | |
| 17. INFORMANT MRS LOUISE S. SHACKELFORD | | | | ADDRESS EASTON, MD. | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ESOPHAGEO-TRACHEAL FISTULA 1 MO | | | | (A) DUE TO | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CA LUNG 5 MO | | | | (B) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) DUE TO | |
| 19A. DATE OF OPERATION 2/1/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/1/67 to 3/9/67 that (I) (we) lost saw the deceased alive on 3/8/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Melvin H. Epstein | | | | 23B. DATE SIGNED 3/9/67 | |
| 23C. PHYSICIAN'S NAME (Type) MELVIN H. EPSTEIN | | | | 23D. ADDRESS JOHNS HOPKINS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE March 9 1967 | | 24C. NAME OF CEMETERY OR CREMATORY Greenmount Crematory | |
| 24D. LOCATION (City, town, or county) Baltimore, Maryland | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR Henry W. Jenkins & Sons | |
| 24G. DATE REC'D BY HEALTH DEPT. | | 24H. NAME OF REGISTRAR | | 24I. FUNERAL DIRECTOR 4905 York Rd Balt. Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

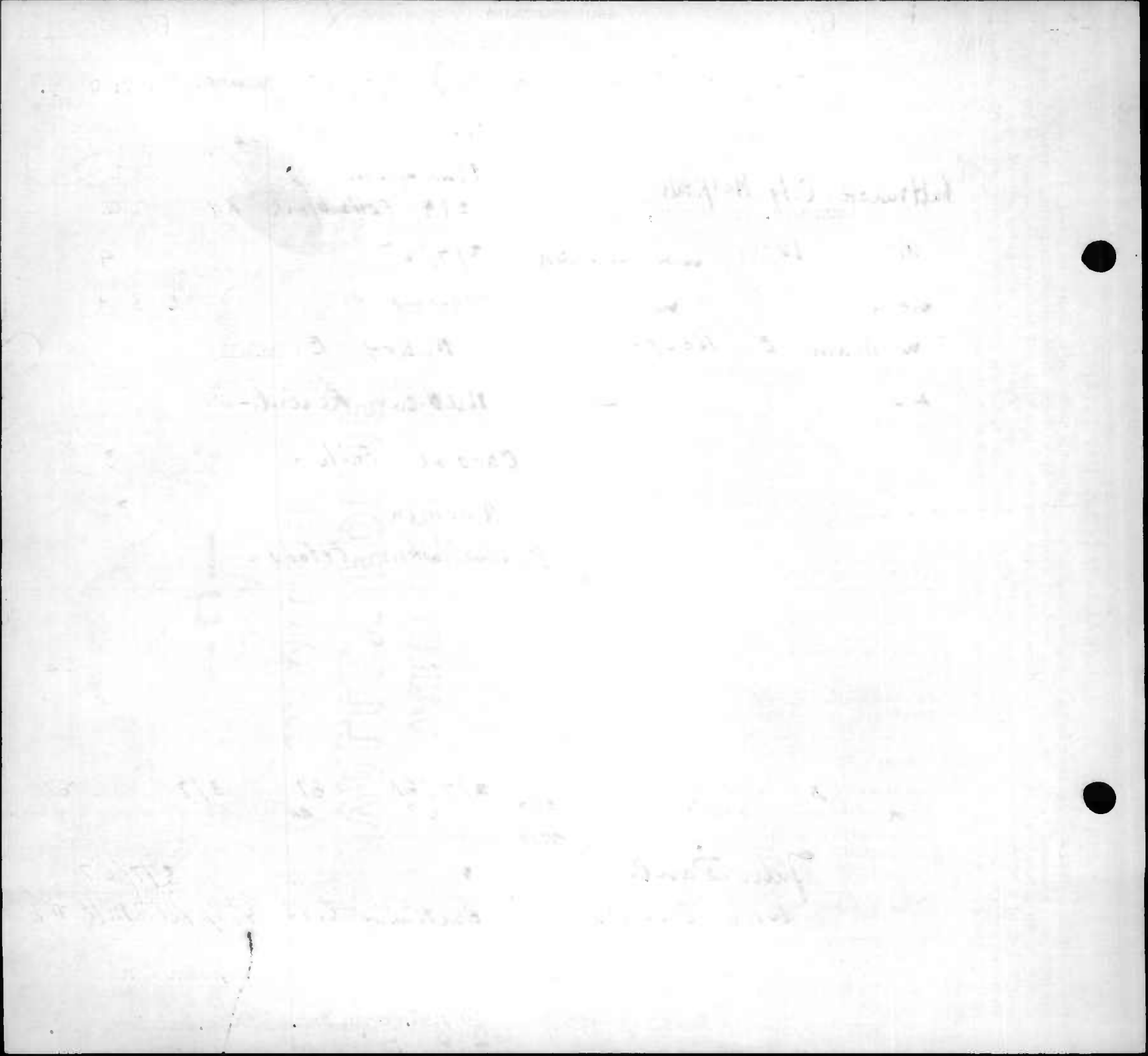
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|--|------------------|--|-----------------------------|---|---|
| BIRTH NO. 67 2390 | | CERTIFICATE OF DEATH | | 67 2390 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WILLIAM H. HALL | | 2. DATE AND HOUR OF DEATH 3/10/67 3:00 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE Co. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 33 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) ESSEX 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) 68 ORVILLE ROAD 21221 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 2-15-85 | 9. AGE (In years last birthday) 82 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Philadelphia Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME WILLIAM H. HALL | | 14. MOTHER'S MAIDEN NAME ANNIE HOLTZ | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217 48 4463 | | 17. INFORMANT ADDRESS Hospital Records | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 I ? Myocardial infarct vs. fulminant Embolus ABCD | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO MAX | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natally medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/14 19 67 to 3/10 19 67, that (I) (we) last saw the deceased alive on 3/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE F. I. BEIGE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/10/67 | |
| 23C. PHYSICIAN'S NAME (Type) F. I. BEIGE | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3, 13, 67 | | 24C. NAME OF CEMETERY or CREMATORY Sherwood | |
| 24D. LOCATION (City, town, or county) (State) Cockeysville, Balto, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 10 1967 | | | |
| 25B. NAME OF REGISTRAR R. E. Jackson | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson, Towson, Md. 21204 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2391 4 | |
|---|--|---|--|---|--|
| BIRTH NO. 67 2391 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Hooper Baby Boy (Mary)</i> | | | |
| 2. DATE AND HOUR OF DEATH <i>3/7/67</i> | | 7:00 p.m. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Baltimore Co.</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hospitals</i> 21224 <i>4940 Eastern Ave. Baltimore, Maryland</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Time in min</i> RURAL <i>53-00</i> | | | |
| 5. SEX <i>Male</i> 6. RACE <i>White</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>never married</i> | | D. STREET ADDRESS (If rural, give location) <i>219 Falls brook Rd.</i> 21204 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>none</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | 13. FATHER'S NAME <i>William E. Hooper</i> | | | |
| 14. MOTHER'S MAIDEN NAME <i>Mary E. McNally</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | |
| 16. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT <i>4940 Eastern Avenue</i> <i>Medical Record - BCH</i> | | | |
| 18. <i>720.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Cardiac Failure</i> (B) <i>Anemia</i> (C) <i>Erythroblastosis Fetalis</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>?</i> <i>?</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <i>(M)</i> (this hospital) attended the deceased from <i>3/7/67</i> 19 <i>67</i> to <i>3/7</i> 19 <i>67</i> , that <i>(M)</i> (we) last saw the deceased alive on <i>3/7</i> 19 <i>67</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <i>(did not)</i> view the body after death. | | | | | |
| 23A. SIGNATURE <i>Julio Zavala</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>3/7/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Julio Zavala</i> | | 23D. ADDRESS <i>4940 Eastern Avenue</i> 21224 <i>Baltimore City Hospital - Balt. Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3/9/1967</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR <i>John A. Moran Inc.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>3000 E. Baltimore St.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2392 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2392 | |
|--|-------------------------|--|---|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) ANDREWS BELLE | | | 2. DATE AND HOUR OF DEATH MARCH 8TH 1967 140 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL | | | A. STATE MARYLAND | | |
| (If not in hospital or institution, give street address or location) | | | B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 124 S. POTOMAC ST. | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED MARRIED | 8. DATE OF BIRTH 07-08-1892 | 9. AGE (In years last birthday) 74 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? AMERICAN | | 13. FATHER'S NAME UNKNOWN BENNETT | | 14. MOTHER'S MAIDEN NAME UNKNOWN HUNTER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-22-4807 | | 17. INFORMANT ADDRESS Mr. Joseph Andrews 124 S. Potomac St. | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CEREBRAL THROMBOSIS | | | INTERVAL BETWEEN ONSET AND DEATH 30 HOURS | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HYPERTEENSION | | | 6-7 YEARS | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | | | 6-7 YEARS | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-7-1967 to 3-8-1967 , that (I) (we) last saw the deceased alive on 3-8-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Fridtjofur Bjornsson | | | | 23B. DATE SIGNED 3-8-67 | |
| 23C. PHYSICIAN'S NAME (Type) FRIDTJOFUR BJORNSSON, D. | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/10/67 | | 24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR John A. Moran, Inc. | |
| 25C. FUNERAL DIRECTOR ADDRESS 3000 E. Baltimore St | | MAR 10 1967 | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2393 | |
|---|---------|---|------------------|---|----------------------------------|
| BIRTH NO. 67 2393 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | | |
| | | Julia Svitt (JULIA M. SVITT) | | | |
| 2. DATE AND HOUR OF DEATH | | 9 Mar 67 3 ⁰⁰ A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Fayette Conv. and Nurs. Home | | Maryland Baltimore | | | |
| 1105 E. Fayette Street | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| 431 Oriole Ave. # 21224 | | D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. AGE (In years last birthday) |
| Female | White | Widowed | 1-1-1868 | 99 (99) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired | | House Work | | Czechoslovakia | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| ? Stez | | Unknown | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 214 56 9260J | | Mary J. Hobine 431 Oriole Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 491X-1260X | | Broncho pneumonia | | 2 wks | |
| 19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 Leg amput - diab mell - ascro | | No | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED (While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 22. I certify that (I) (J. Hulla) attended the deceased from Oct. 28, 1960 to 9 Mar 1967, that (I) (J. Hulla) last saw the deceased alive on 9 Mar 1967 and that in (my) (J. Hulla) opinion death occurred on the date and hour and from the causes stated above. (I) (J. Hulla) (did) (did not) view the body after death. | | 23A. SIGNATURE | | 23B. DATE SIGNED | |
| | | J. Hulla | | 9 Mar 67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| J. Hulla | | 2214 E. Fayette Street 21231 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 3-13-67 | | Oak Lawn Cemetery | |
| 24D. LOCATION (City, town, or county) | | 24E. DATE REC'D BY HEALTH DEPT. | | 24F. NAME OF REGISTRAR | |
| 7225 Eastern Blvd. Ba. Co., Md. | | MAR 13 1967 | | Charles S. Jailer | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| | | | | 6224 Eastern Ave Balto., 21224, Md | |

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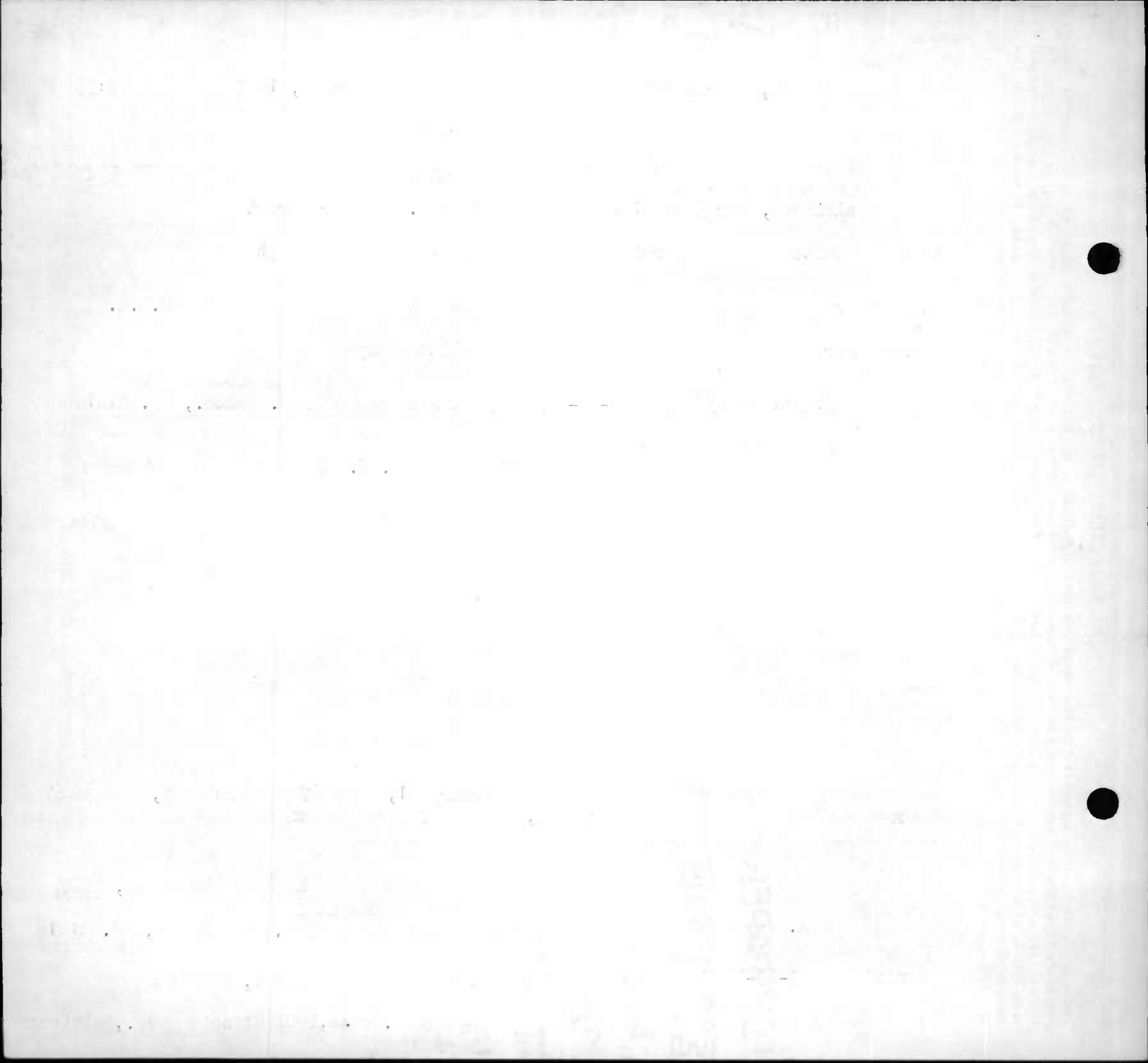
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---|--|---------|--|---|--|------------------------|--|
| P-412 | | 67 2394 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2394 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Phillips John S.</i> | | | | 3-7-67 1:10 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>SINAI HOSPITAL</i> | | | | A. STATE <i>MD</i> B. COUNTY <i>Balto. Co</i> | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore ESSEX 53-00</i> | | | |
| 5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i> | | | | D. STREET ADDRESS (If rural, give location) <i>310 Essex Ave</i> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DRIVER</i> | | | | 8. DATE OF BIRTH <i>8-27-15</i> 9. AGE (In years lost birthday) <i>51</i> | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY <i>ANCHOR MOTOR FREIGHT</i> | | | | 11. BIRTHPLACE (State or foreign country) <i>MD</i> | | | |
| 13. FATHER'S NAME <i>?</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES WW II</i> | | | | 14. MOTHER'S MAIDEN NAME <i>HENRIETTA DURKE</i> | | | |
| 16. SOCIAL SECURITY NO. <i>212-07-3544</i> | | | | 17. INFORMANT <i>JANET PHILLIPS</i> | | | |
| 18. <i>15-7X I</i> | | | | ADDRESS <i>ABOVE</i> | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) <i>Ca of the head of the Pancreas</i> DUE TO (B) <i>Metastases (Generalized)</i> DUE TO (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION <i>0</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3-5-67</i> to <i>3-6-67</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>R. Theodore</i> | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>ROGER THEODORE</i> | | | | 23D. ADDRESS <i>SINAI HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | | | 24B. DATE <i>3/10/67</i> | | | |
| 24C. NAME OF CEMETERY or CREMATORY <i>OAK LAWN</i> | | | | 24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 13 1967</i> | | | | 25B. NAME OF REGISTRAR <i>P. E. Johnson</i> | | | |
| 25C. FUNERAL DIRECTOR <i>J. J. Connelly Sons</i> | | | | ADDRESS <i>300 MACE</i> | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

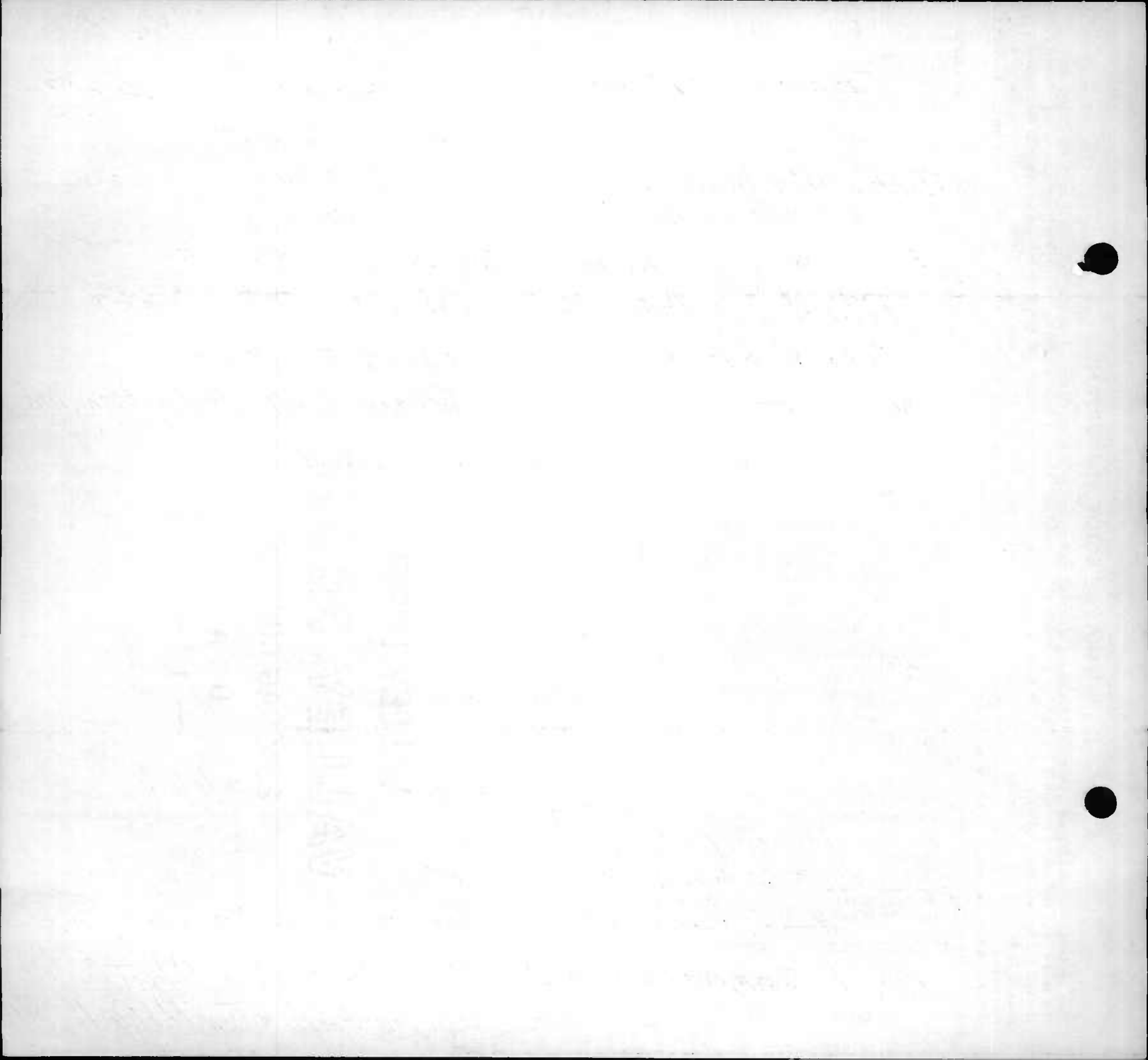
| BALTIMORE CITY HEALTH DEPARTMENT | | | | REGISTERED NO. | |
|---|--|---|--|--|--|
| BIRTH NO. 67 2395 | | CERTIFICATE OF DEATH | | 67 2395 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) PERRY, Ambros Clinton | | 2. DATE AND HOUR OF DEATH March 9, 1967 5:35 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital 27 3900 Loch Raven Blvd Baltimore, Maryland 21218 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 25-04 | | | |
| D. STREET ADDRESS 3721 S. Hanover Street | | E. DATE OF BIRTH 7/2/16 | | | |
| 5. SEX Male | | 6. RACE White | | 9. AGE (In years last birthday) 50 | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 11. BIRTHPLACE (State or foreign country) Georgia | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Alfred Perry | |
| 14. MOTHER'S MAIDEN NAME Alice Sharp | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6/12/41 to 8/9/45 | | 16. SOCIAL SECURITY NO. 240-76-7358 | |
| 17. INFORMANT VA Hospital Records | | ADDRESS 3900 Loch Raven Blvd. Balto., Md. 21218 | | 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | |
| 19. DATE OF OPERATION | | 20. AUTOPSY? (Yes or No) Yes | | 21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 22. I certify that (X) (this hospital) attended the deceased from February 1, 1967 to March 9, 1967, that (X) (we) last saw the deceased alive on March 9, 1967 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. | | 23. SIGNATURE A. Jay Block M.D. | | 24. DATE SIGNED March 10, 1967 | |
| 25. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 26. NAME OF REGISTRAR Robert E. Taylor | | 27. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hwy., Baltimore | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|---------------------|--|--|--|----------------------------|---|-----------------------------|
| T-630 | | 67 2396 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2396 | |
| CERTIFICATE OF DEATH | | | | | | | |
| BIRTH NO. 67 2396 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BESSIE TROTT | | 2. DATE AND HOUR OF DEATH 3/8/67 12:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bolton Hill Nursing Home 90 Lafayette & John St. | | | | A. STATE MD. B. COUNTY Calvert Co. | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Huntingtown 34-00 | | | | D. STREET ADDRESS (If rural, give location) (Rural) | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH July 28, 1897 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Calvert Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John W. Lyons | | | | 14. MOTHER'S MAIDEN NAME Elizabeth Howes | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT ADDRESS Jackson Trott, Huntingtown, Md. | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/17/66 19 to 3/8/67 19, that (I) (we) last saw the deceased alive on 3/8/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE [Signature] | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/8/67 | |
| 23C. PHYSICIAN'S NAME (Type) HOWES JENNALINE | | | | 23D. ADDRESS 930 WHITELOCK ST, BALT, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Mar 13, 1967 | | 24C. NAME OF CEMETERY or CREMATORY Miranda Cemetery | | 24D. LOCATION (City, town, or county) (State) Huntingtown, Calvert Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR A.A. [Signature] | | ADDRESS Port Republic, Md. | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|------------------|--|-----------------------------|--|---------------------------------|---|--|
| L-520 | | 67 2397 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2397 | |
| BIRTH NO. | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type, or Print) Sister Mary Perpetuella Lynch | | | | March 2, 1967 5:00 AM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL | | | | A. STATE MARYLAND | | | |
| (If not in hospital or institution, give street address or location) | | | | B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 4500 PARK HEIGHTS AVE. | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 7/15/36 | 9. AGE (In years lost birthday) 30 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER | | 10B. KIND OF BUSINESS OR INDUSTRY EDUCATION | | 11. BIRTHPLACE (State or foreign country) BALTIMORE | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WALTER LYNCH | | | | 14. MOTHER'S MAIDEN NAME DELORES SHIPLEY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT CONVENT RECORDS ST. AMBROSE 4500 PARK HIGTS AVE. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 201X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Pulmonary Insufficiency DUE TO (B) Radiacin Pneumonia / Lung DUE TO (C) Pulmonary Hodgkins Disease | | INTERVAL BETWEEN ONSET AND DEATH 1 yr 6 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not White <input type="checkbox"/> Work At Work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from March 1, 1967 to March 2, 1967, that (2) (we) last saw the deceased alive on March 1, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Joseph Silva | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED March 2, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH SILVA | | | | 23D. ADDRESS M.D. THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE MARCH 4, 1967 | | 24C. NAME OF CEMETERY OR CREMATORY SISTERS CEMETERY | | 24D. LOCATION (City, town, or county) (State) GLEN ARM, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR R. E. Fairbank | | 25C. FUNERAL DIRECTOR RAYMOND CURRAN | | ADDRESS 817 SCARLETT DR TOWSON, MD. 21204 | |

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BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2398

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

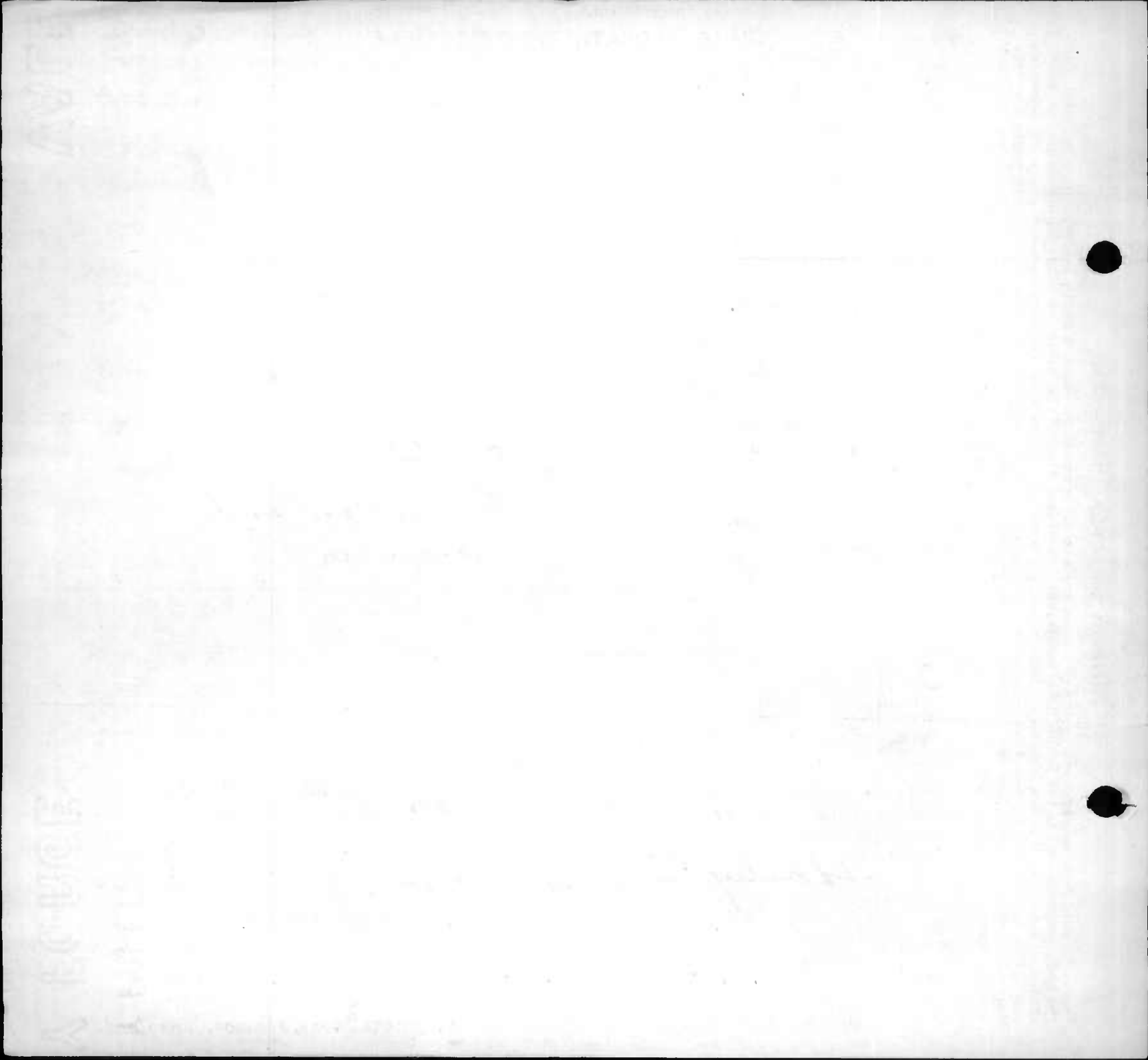
| | | | |
|--|-------------------------|---|------------------------------------|
| 1. NAME OF DECEASED (Type or Print) <i>JOHN GRISH</i> | | 2. DATE AND HOUR OF DEATH <i>3-2-67 4:12 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>31 BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> D. STREET ADDRESS (If rural, give location) <i>Balto. City Hospitals 4940 Eastern Avenue, -21224</i> | |
| 5. SEX <i>MALE</i> | 6. RACE <i>WHITE</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>6/27/04</i> |
| 9. AGE (In years last birthday) <i>62</i> | | 10. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>NEW JERSEY</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>RECORDS: BCH, 4940 Eastern Ave., Balto. Md. 21224</i> | | ADDRESS | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cachexia & Malnutrition</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Pol. Tbc</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>None</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>76 Mo.</i> <i>aa 5 y.</i> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 19 1965</i> to <i>March 2 1967</i> , that (I) (we) last saw the deceased alive on <i>March 2 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Raymond D. Bahr</i> M.D. | | 23B. DATE SIGNED <i>3/2/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Raymond D. BAHR</i> M.D. | | 23D. ADDRESS <i>4940 Eastern Avenue, Balto. Md. 21224 Baltimore City Hosp.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3-10-67</i> | |
| 24C. NAME OF CEMETERY or CREMATORY <i>Sacred Heart Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Balto, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 13 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farber</i> | |
| 25C. FUNERAL DIRECTOR <i>Walter Papowski</i> | | ADDRESS <i>1005 Dunbar Ave.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

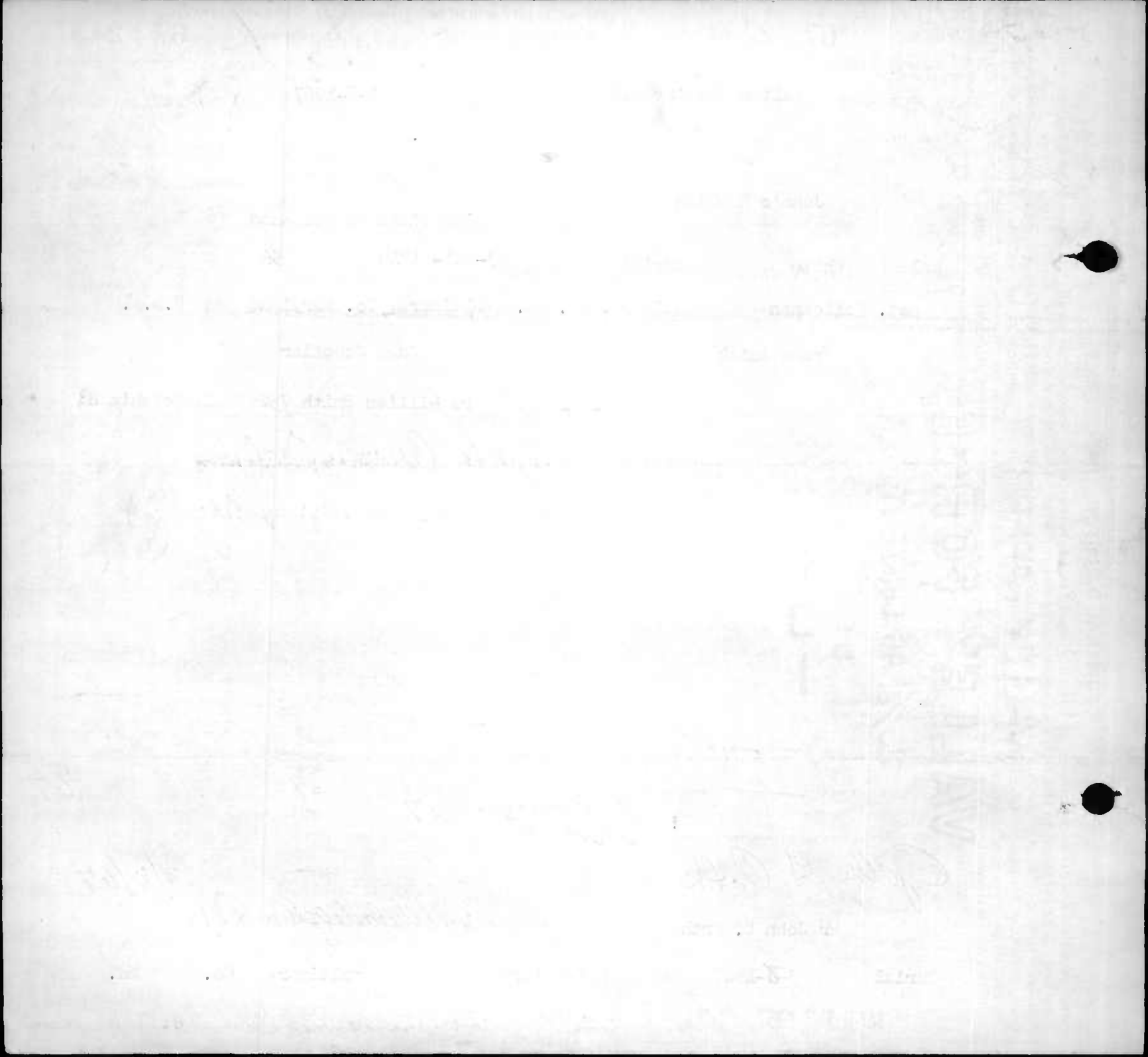
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | |
|---|--|--|--|--|---|-----------------------------------|--|---|--|---|--|-----------------------------|--|--|---|--|
| BIRTH NO. 67 2399 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 2399 | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Edward R. Doughty</u> | | | | | 2. DATE AND HOUR OF DEATH <u>3.2.67</u> <u>9:45 P.M.</u> | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Little Sisters of The Poor</u> (If not in hospital or institution, give street address or location) <u>1200 VALLEY ST</u> <u>Baltimore MD 21202</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1200 VALLEY ST.</u> | | | | | | | | | | | |
| 5. SEX <u>M</u> | | 6. RACE <u>W</u> | | 7. MARRIED, NEVER MARRIED <u>WIDOWED</u> , DIVORCED (specify) | | 8. DATE OF BIRTH <u>3.25.1882</u> | | 9. AGE (In years last birthday) <u>84</u> | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN-Ret.</u> | | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Investments</u> | | | | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u> | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William Doughty</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah MASSEY</u> | | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u> | | | | | 16. SOCIAL SECURITY NO. <u>215-18-3987</u> | | 17. INFORMANT <u>Little Sisters of The Poor</u> | | | | | ADDRESS | | | | |
| 18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <u>C.V.A.</u> DUE TO (B) <u>Generalized arterio</u> DUE TO (C) <u>sclerosis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>3.2.67</u> that (I) (we) last saw the deceased alive on <u>3.2.1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE <u>Stanley Ankudas</u> M.D. | | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED <u>3.10.67</u> | | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>STANLEY ANKUDAS</u> M.D. | | | | | 23D. ADDRESS <u>1101 MAIDEN CHOICE LANE -</u> | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>Mar. 6, 1967</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | | | 24D. LOCATION (City, town, or county) <u>BAL (State) MD</u> | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 13 1967</u> | | | | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | | | | 25C. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u> | | | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

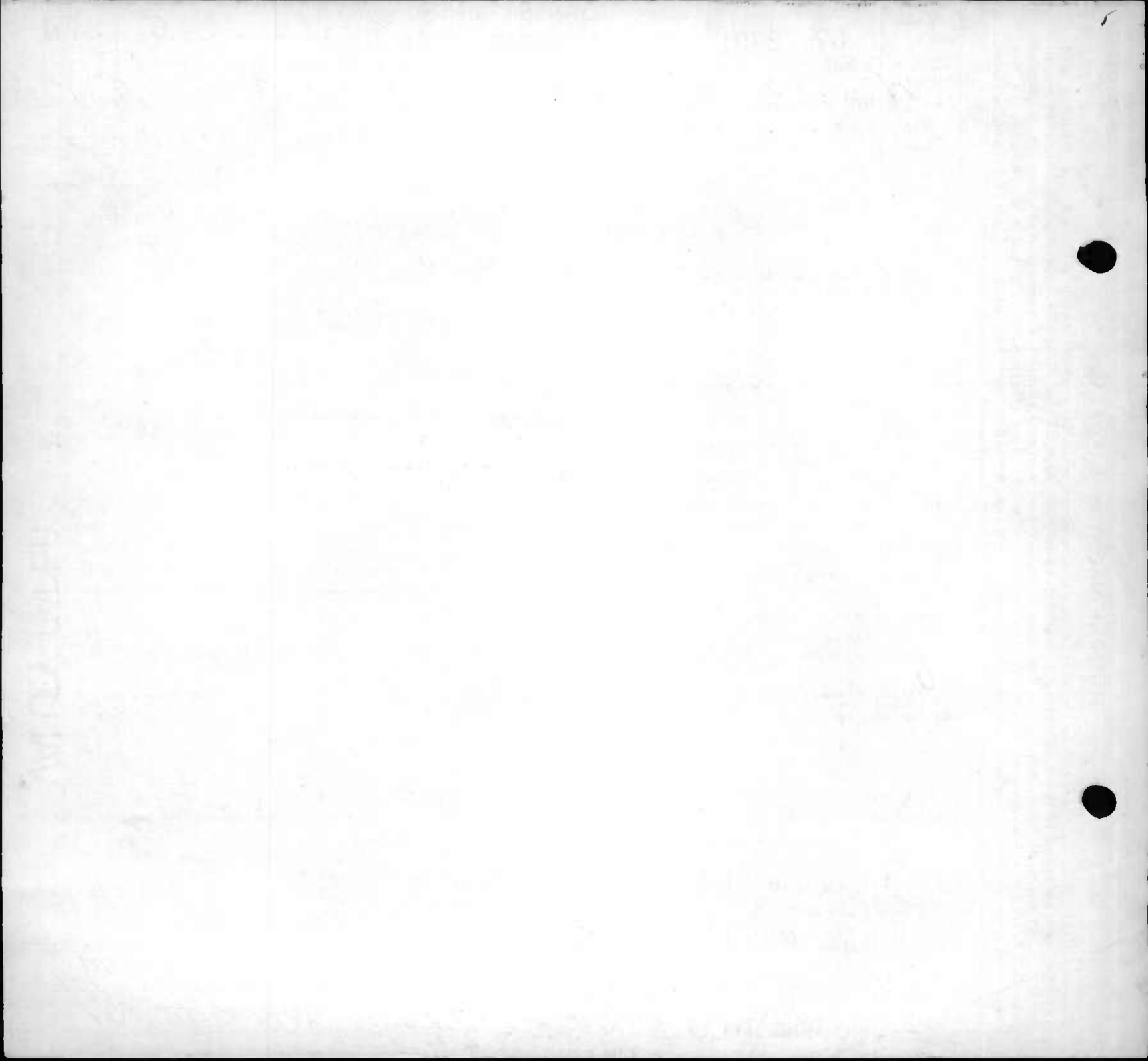
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|--|---|--|---|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2400 | | | | |
| BIRTH NO. 67 2400 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Walter Thomas Smith</u> | | | | | 2. DATE AND HOUR OF DEATH <u>3-5-1967</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 John's Hopkins</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balts. Co.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>7528 Philadelphia Road #6</u> | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>3-15-1910</u> | 9. AGE (In years last birthday) <u>56</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Policeman</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Co. Md.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Co. Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>Frank Smith</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Scheeler</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>216-10-2079</u> | | 17. INFORMANT <u>Mrs William Smith 7528 Philadelphia Rd</u> | | | | |
| 18. <u>420.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Coronary Occlusion</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic Coronary Arteriosclerosis</u> | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>19 57</u> to <u>19 67</u> , that (I) (we) last saw the deceased alive on <u>February 19 67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>John G. Orth</u> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>3/10/67</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr John G. Orth</u> | | | | | 23D. ADDRESS M.D. <u>8019 Philadelphia Rd.</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 24B. DATE <u>3-8-1967</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 13 1967</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Faldut</u> | | | 25C. FUNERAL DIRECTOR <u>Largen Funeral Home 7401 Belair Road</u> | | ADDRESS (34) | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2401 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2401 | |
|---|---------------------|---|---|---|--------------------------------|--|--|
| M.E. CASE NO. | | | | BIRTH NO. 67 2401 | | | |
| 1. NAME OF DECEASED (Type or print) WARCHAL CASIMER | | | | 2. DATE AND HOUR OF DEATH MARCH 7 67 1 30 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND BOLTON HILL NURSING HOME <small>(If not in hospital or institution, give street address or location)</small> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY MD. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MD. 1-03 D. STREET ADDRESS (If rural, give location) 513 SOUTH MILTON AVE. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH MAR. 14 1914 | 9. AGE (In years last birthday) 53 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTING PRESSMAN | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) NEW JERSEY | |
| 13. FATHER'S NAME WALTER | | | | 14. MOTHER'S MAIDEN NAME FRANCIS OBERC | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> Chronic Cardio-vascular disease | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1962 | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initialed medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-24 1967 to 3-7 1967 , that (I) (we) lost saw the deceased alive on 3-7 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE H. Edmund Levin M.D. | | | | 23B. DATE SIGNED 3-8-67 | | | |
| 23C. PHYSICIAN'S NAME (Type) H. EDMUND LEVIN M.D. | | | | 23D. ADDRESS 1190 W. Belvedere Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/11/67 | | 24C. NAME OF CEMETERY or CREMATORY St. Stanislaus | | 24D. LOCATION (City, town, or county) (State) Baltimore (Md) | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. Feltman | | 25C. FUNERAL DIRECTOR J. Fisher (1930 Eastern Ave) | | ADDRESS | |



67 2402

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2402

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILBUR F. HARRIS

2. DATE AND HOUR PRONOUNCED DEAD

3-6-67

1:40 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

18 W. PRESTON STREET - Amb. Crew #4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

18 W. Preston Street 21201

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

divorced

8. DATE OF BIRTH

6/14/07

9. AGE (In years
last birthday)

60-59

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR INDUSTRY

Kennilworth

11. BIRTHPLACE (State or foreign country)

Boston, Mass.

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

George C. Harris

14. MOTHER'S MAIDEN NAME

Eliza Cotreau

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

023-07-4875

17. INFORMANT

Mr. Richard Harris

ADDRESS

18. 5-8-10

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty alteration of liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Partial

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-6-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/11/67

23C. NAME of CEMETERY or CREMATORY

Holy Cross

23D. LOCATION

(City, town, or county)

(State)

Malden, Massachusetts

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 67 2403 | |
|---|---------------------|---|------------------------------------|--|--|--|--|
| BIRTH NO. 67 2403 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Henry Caver | | 2. DATE AND HOUR OF DEATH March 10, 1967 3:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2755 W North Ave | | | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8/29/12 | | 9. AGE (In years last birthday) 54 | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer | | 10B. KIND OF BUSINESS OR INDUSTRY Taxi | | 11. BIRTHPLACE (State or foreign country) Birmingham Ala | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Henry Lee Caver | | | | 14. MOTHER'S MAIDEN NAME Sadie Mae Butler | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs Laurence Caver | | ADDRESS 2755 W North Ave | |
| 18. 720.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) Congestive heart failure DUE TO (B) Coronary Ischemia DUE TO (C) Atherosclerosis | | INTERVAL BETWEEN ONSET AND DEATH unknown unknown unknown | |
| | | | | | | | |
| | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-6-1967 to 3-10-1967 , that (I) (we) last saw the deceased alive on 3-6-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. did in Lutheran hospital | | | | | | | |
| 23A. SIGNATURE Frank A. Saunders | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) FRANK A. SAUNDERS | | | | 23D. ADDRESS M.D. 1029 N. Stricker St. Baltimore 21217 Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/14/67 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Adolphus Halstead | | ADDRESS 1206 W North Ave | |

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67 2404

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2404

BIRTH NO.

M.E. CASE NO.

| | | | | | |
|---|------------------|--|------------------|--|---|
| 1. NAME OF DECEASED (Type or Print) | | LEROY GANT | | 2. DATE AND HOUR PRONOUNCED DEAD March 10, 1967 9:50 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 00 324 E. LaFayette Street | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1205 D. STREET ADDRESS (If rural, give location) 324 E. LaFayette Street | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 50 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur | | 10B. KIND OF BUSINESS OR INDUSTRY Taxi Cab | | 11. BIRTHPLACE (State or foreign country) N Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME Charlie Gant | | | |
| 14. MOTHER'S MAIDEN NAME Sally | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs Janice Mae Gant 1418 Holbrook St | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 15 IX I Carcinoma of stomach ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 10, 1967 | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 3/13/67 | | 23C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery | |
| 23D. LOCATION Baltimore Md | | 24A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | | |
| 24B. NAME OF REGISTRAR <i>Adolphus E. Halstead</i> | | 24C. FUNERAL DIRECTOR Adolphus Halstead 1206 W North Ave | | | |

WALTER POWELL

2nd Lt.

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C-455

67 2405

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2405

BIRTH NO.

M.E. CASE NO.

| | | | |
|---|---------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) ANNA COLEMAN | | 2. DATE AND HOUR PRONOUNCED DEAD 3-7-67 9:50 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2100 Greenmount Avenue - Amb. Crew #3 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2100 Greenmount Avenue 21218 | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) ? | 8. DATE OF BIRTH ? |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY ? | 9. AGE (In years last birthday) 54 ? |
| 11. BIRTHPLACE (State or foreign country) ? | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |

| | | | | |
|---|---|--|--|--|
| MEDICAL CERTIFICATION | 18. 443X CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic and hypertensive cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C) | | | INTERVAL BETWEEN ONSET AND DEATH |
| | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| | 19A. DATE OF OPERATION 0 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| | 21F. HOW DID INJURY OCCUR? | | | |
| | 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| ACTUAL SIGNATURE Werner U. Spitz DATE SIGNED 3-7-67 | | | | |
| EXAMINER'S NAME (Type) WERNER U. SPITZ, M.D. | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | 23B. DATE 3/10/67 | 23C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery | 23D. LOCATION (City, town, or county) (State) A A County Md | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | 24B. NAME OF REGISTRAR Adolphus Halstead | 24C. FUNERAL DIRECTOR ADDRESS 1206 W North Ave | | |

WILLIAM HODGKIN

WILLIAM HODGKIN

WILLIAM HODGKIN

WILLIAM HODGKIN

WILLIAM HODGKIN

WILLIAM HODGKIN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|
| 67 2406 | | | | | 67 2406 | | | | |
| BIRTH NO. | | | | | Registered No. | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) GEORGE COX | | | | | 2. DATE AND HOUR OF DEATH 3:45 PM 3/9/67 | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL 301 St Paul Place Baltimore | | | | | A. STATE Md. B. COUNTY Baltimore | | | | |
| 5. SEX M | | | | | 6. RACE N | | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | | | | 8. DATE OF BIRTH 9-21-17 | | | | |
| 9. AGE (In years last birthday) 49 | | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Operator | | | | |
| 11. BIRTHPLACE (State or foreign country) N Carolina | | | | | 12. CITIZEN OF WHAT COUNTRY? U S A | | | | |
| 13. FATHER'S NAME Noah Cox | | | | | 14. MOTHER'S MAIDEN NAME Florence | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. | | | | |
| 17. INFORMANT Dr M. Z. Khan | | | | | ADDRESS Mercy Hospital | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, apoplexy, etc. It means the disease, injury or complication which caused death.) 444 X I | | | | | CAUSE OF DEATH (A) Hypertension, Arteriosclerosis (B) Epilepsy (C) Anemia | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | INTERVAL BETWEEN ONSET AND DEATH ? Years 1 day | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 X | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED X | | | | |
| 20A. AUTOPSY? (Yes or No) 1 | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-9-67 19 to 3/9/67 19, that (I) (we) last saw the deceased alive on 3:45 PM 3/9/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE M. Z. Khan | | | | | 23B. DATE SIGNED 3/9/67 | | | | |
| 23C. PHYSICIAN'S NAME (Type) M. ZAFRULLAH KHAN | | | | | 23D. ADDRESS Mercy Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 3/14/67 | | | | |
| 24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery | | | | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | | |
| 25C. FUNERAL DIRECTOR Adolphus Halstead | | | | | ADDRESS 1206 W North Ave | | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2407 | |
|--|-------------------------|---|---------------------------------|---|---|
| BIRTH NO. 67 2407 | | CERTIFICATE OF DEATH | | 67 2407 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Lewis, Robia.</i> | | 2. DATE AND HOUR OF DEATH <i>3/11/67</i> <i>8:30 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Baltimore.</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>18-02</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Lincoln Memorial Nursing Home</i> <i>27 N. Carey Street.</i> <i>Baltimore, Maryland 21223</i> | | D. STREET ADDRESS (If rural, give location) <i>27 N. Carey St.</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>unknown</i> | 8. DATE OF BIRTH <i>1869</i> | 9. AGE (In years last birthday) <i>98</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unknown</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>unknown</i> | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>unknown</i> | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>unknown</i> | | 17. INFORMANT <i>Lincoln Memorial Nursing Home 27 N Carey St. Balt 21223 Md</i> | |
| 18. <i>420.11</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Coronary Thrombosis.</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i></i> | | | |
| (C) <i></i> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>8/25</i> <i>1966</i> to <i>3/11</i> <i>1967</i> . | | that (I) (we) last saw the deceased alive on <i>3/11</i> <i>1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE <i>John J. ...</i> | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) <i>Horris ...</i> | |
| 23D. ADDRESS <i>5519 Kennison Rd. Beth. Md.</i> | | 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3/13, 67</i> | |
| 24C. NAME OF CEMETERY OR CREMATORY <i>Mt Calvary</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 13 1967</i> | |
| 25B. NAME OF REGISTRAR <i>...</i> | | 25C. FUNERAL DIRECTOR <i>...</i> | | ADDRESS <i>2302 W. North Ave.</i> | |

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Handwritten signature

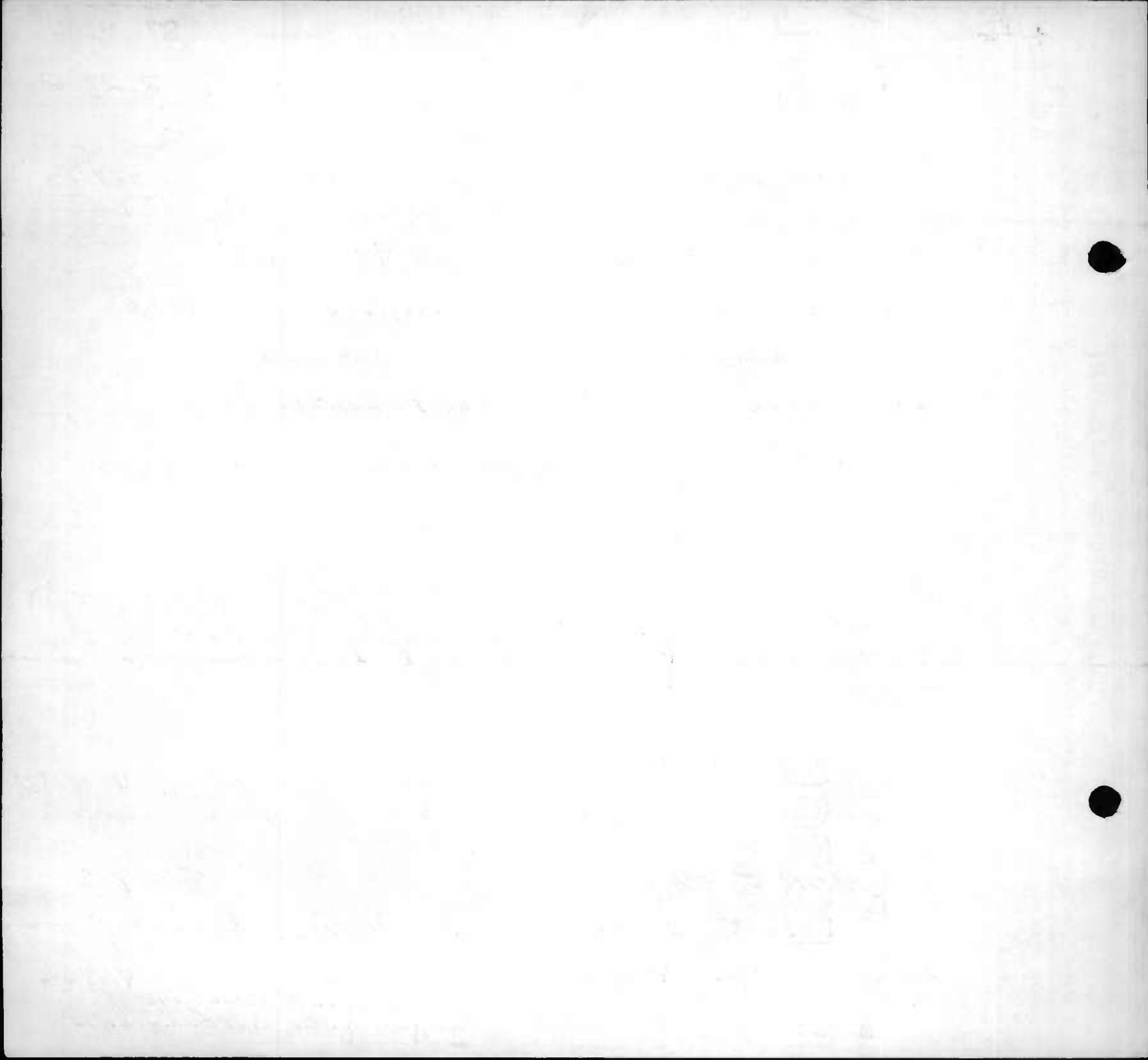
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2408 | |
|--|---------------------|--|-------------------------------------|--|---|
| BIRTH NO. 67 2408 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Frances Nichols | | 2. DATE AND HOUR OF DEATH 3-9-67 2:28 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | 14-03 | |
| | | D. STREET ADDRESS (If rural, give location) Pennsylvania Ave. 1917 | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 11-22-89 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Domestic | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Chart - Hospital | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 434.1 I | | CAUSE OF DEATH (A) Congestive Heart Failure DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 8 yrs. | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Rising SUN (That is Serum UREA) NITROGEN | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from Feb. 19 1967 to March 9 1967 , that (1) (we) last saw the deceased alive on 3/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robb E. Moses | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/9/67 | |
| 23C. PHYSICIAN'S NAME (Type) Robb E. Moses | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-14-67 | | 24C. NAME OF CEMETERY or CREMATORY Antioch Baptist Church | |
| | | 24D. LOCATION Madison | | 24E. STATE Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robb E. Moses | | 25C. FUNERAL DIRECTOR Geo. L. Schwab Funeral Home | |
| | | | | ADDRESS Manassas 2101 Antioch Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--|---------------------|--|---|---|--|--|--|--|--|---|--|--|--|--|
| BIRTH NO. 67 2409 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 67 2409 | | | | |
| 1. NAME OF DECEASED (Type or Print) ABBOTT Martha V | | | | | | | | | | 2. DATE AND HOUR OF DEATH 3-9-67 - 1:50 PM | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANN ARUNDEL CO | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) ANNAPOLIS | | | | | | | | | | D. STREET ADDRESS (If rural, give location) 52-10 118 Sunset drive | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | | 8. DATE OF BIRTH 11/7/99 | | 9. AGE (In years lost birthday) 68 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | |
| 13. FATHER'S NAME Henry B Cox | | | | | 14. MOTHER'S MAIDEN NAME MARY ELLA SARGENT | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 212 18-5883 | | 17. INFORMANT ST VERNON ABBOTT | | | ADDRESS #4 | | | | | |
| 18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Carc. of Bladder ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carc. of Bladder | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION ON me | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/26/66 19 to 3/9 19 67 , that (I) (we) last saw the deceased alive on 3/8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE Spencer D. Munn | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED 3/9/67 | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | 24B. DATE 3-11-67 | | 24C. NAME of CEMETERY or CREMATORY OXFORD CEMETERY | | | 24D. LOCATION (City, town, or county) (State) OXFORD MD. | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | | 25B. NAME OF REGISTRAR Robert E. Finkbeiner | | | 25C. FUNERAL DIRECTOR John M. Long | | | ADDRESS Annapolis, Md. | | | | | |

Burial after Oxford Cemetery
John M. Thompson, Chicago, Ill.
M.D.

John M. Thompson

31

12/12

30

2 Vernon Abbott #1

May 3 1890

May 1890

Home

May 1890

May 1890

68

PP 11

May 1890

May 1890

1
G-650

67 2410

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2410

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FLORENCE GREEN

2. DATE AND HOUR PRONOUNCED DEAD

3-7-67

9:50 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

664 W. Fayette Street 21201

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

Feb. 20, 1922 45

9. AGE (In years
last birthday)

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Jesse Green

14. MOTHER'S MAIDEN NAME

Estelle Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mary Com

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Fatty alteration of liver

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Apical tuberculosis, right, active

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. Partial (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

WERNER U. SPITZ, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-7-67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/12/67

23C. NAME OF CEMETERY or CREMATORY

Round Hill Cem.

23D. LOCATION

(City, town, or county)

(State)

Greenville Cty. Va.

24A. DATE REC'D BY HEALTH DEPT.

MAR 13 1967

24B. NAME OF REGISTRAR

Robert E. Fairman

24C. FUNERAL DIRECTOR

W/M MARCH 928 E North Ave

ADDRESS

MALIBU POLICE

Wm. L. B. R.

C-200

| | | | |
|--|-------------------------|--|--|
| BIRTH NO. 67 2411 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) FRANK C. CHASE | | 2. DATE AND HOUR PRONOUNCED DEAD March 11, 1967 3:45 P M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 608 S. Wolfe Street | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH Oct. 8, 1905 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman | | 10B. KIND OF BUSINESS OR INDUSTRY Retired - U. S. Navy Ship ceiler | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland |
| 13. FATHER'S NAME Michael Chase | | 14. MOTHER'S MAIDEN NAME Catherine Wasik | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6/12/22 - 5/9/42 | | 16. SOCIAL SECURITY NO. 220-14-3491 | 17. INFORMANT ADDRESS Mrs. Rose Graybill - 6619 Hudson Street |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic and Hypertensive Cardiovascular Disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE Mar 15, 1967 | 23C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | 24C. FUNERAL DIRECTOR ADDRESS George A. Weber - 705 S. Ann Street #21231 |
| 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |

WILLIE FORGE

EXHIBITION

1934

CHAS. H. HOLT

FUNERAL DIRECTOR: IMPORTANT

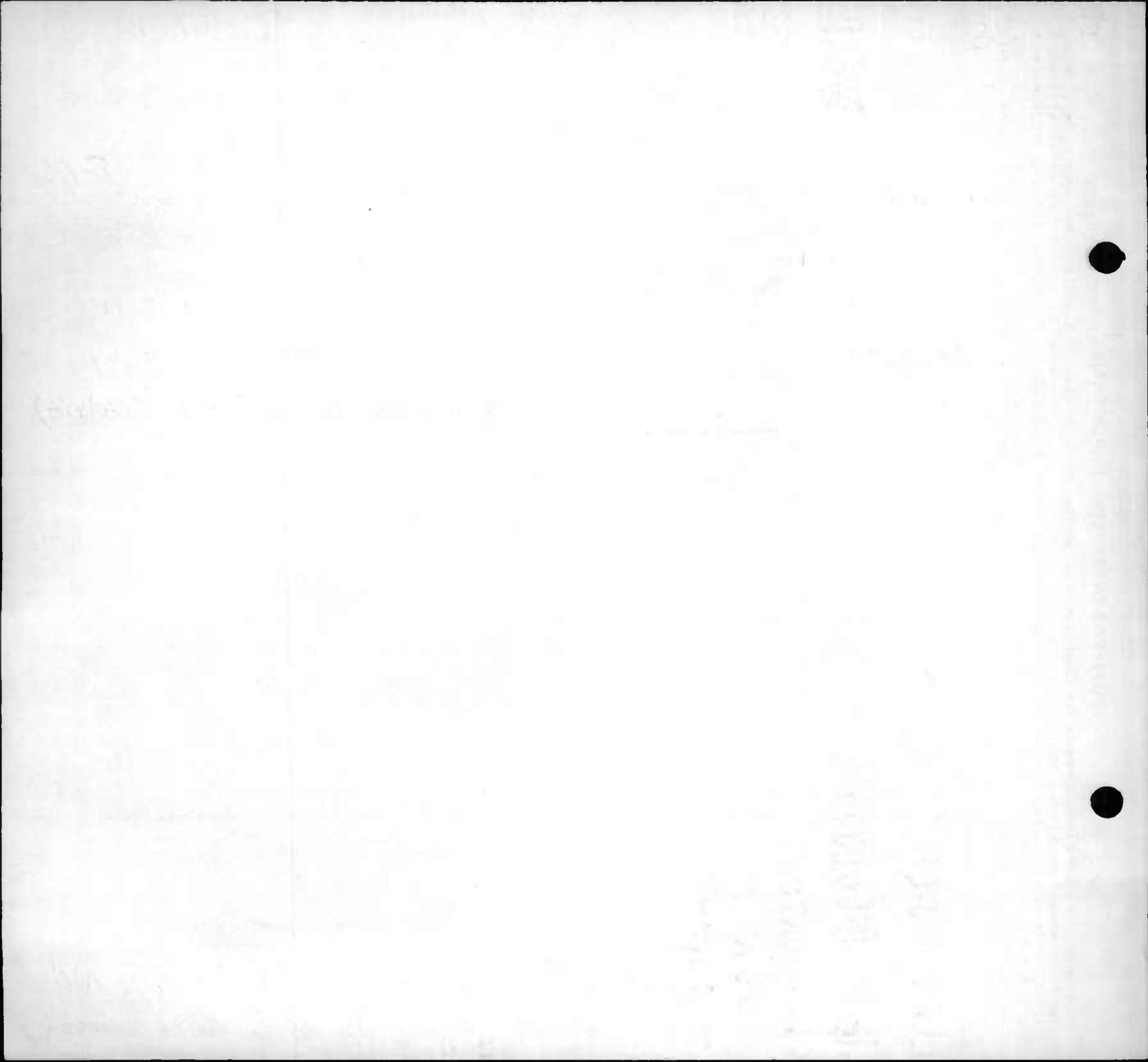
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2412 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2412 | |
|---|-----------------------------|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) FRANCIS D. BUTLER | | | 2. DATE AND HOUR OF DEATH 3/9/67 1:45 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) 15-03 D. STREET ADDRESS (If rural, give location) 1811 Moreland ave. | | |
| 5. SEX M | 6. RACE negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 12/25/91 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur (retired) | | 10B. KIND OF BUSINESS OR INDUSTRY unkn | 11. BIRTHPLACE (State or foreign country) md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME unkn | | | 14. MOTHER'S MAIDEN NAME Lucy Blair | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 214-01-6407 | 17. INFORMANT ADDRESS Henrietta White - 2418 Woodbrook ave | | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Hypertensive Arteriosclerotic Heart Disease 8 yrs + DUE TO (B) Arteriosclerosis - Hypertension 8 yrs + DUE TO (C) _____ | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ① Gout - D.I. Malignancy of the Ra | | | INTERVAL BETWEEN ONSET AND DEATH 8 yrs + | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 4 19 59 to March 9 19 67 , that (I) (we) last saw the deceased alive on 21 Feb 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C. R. Paulson | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3-11-67 |
| 23C. PHYSICIAN'S NAME (Type) Charles Robert Paulson | | | 23D. ADDRESS 2534 W. North Ave Baltimore md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3/13/67 | 24C. NAME OF CEMETERY OR CREMATORY West Auburn | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Shelby L. Phatyan Jr - 1701 Mt. Calloch St. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|-------------------------|--|---|--|---|---|---|-----------------------------------|--|
| 67 2413 | | | | | Registered No. 67 2413 | | | | |
| BIRTH NO. 67 2413 | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Pearl Gordon</u> | | | | | 2. DATE AND HOUR OF DEATH <u>3/8/67</u> <u>10:45</u> <u>P</u> M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>33 THE JOHNS HOPKINS HOSPITAL</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If rural, give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>1714 N. BROADWAY</u> <u>21213</u> | | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>NEGRO</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOW</u> | 8. DATE OF BIRTH <u>9-14-88</u> | 9. AGE (In years lost birthday) <u>78</u> | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>DANIEL JOHNSON</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>JENNIE STEPHENY</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Addel BEAT BOSTON 1714 N. BROADWAY</u> | | | | |
| 18. <u>433.014-260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <u>Circular arrest</u> DUE TO (B) <u>Probable CIA</u> DUE TO (C) <u>ACCD</u> | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Bulky molitao</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/8</u> <u>1967</u> to <u>3/8</u> <u>1967</u> , that (I) (we) last saw the deceased alive on <u>3/8</u> <u>1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Reameth Brigham</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>3/8/67</u> | |
| 25C. PHYSICIAN'S NAME (Type) <u>Reameth Brigham</u> | | | | | 23D. ADDRESS M.D. <u>Johns Hopkins Hospital</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3-13-67</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>MT CALVARY CEMETERY</u> | | 24D. LOCATION (City, town, or county) (State) <u>A. A. COUNTY MD</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 13 1967</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u> | | | 25C. FUNERAL DIRECTOR ADDRESS <u>Joseph Knight Funeral Home 1639 N. Broadway</u> | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2414

BIRTH NO. 67 2414

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HELEN MARIE MEYERS

2. DATE AND HOUR PRONOUNCED DEAD

March 8, 1967 7:17 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31 Baltimore City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21224 26-11

D. STREET ADDRESS (If rural, give location)

912 S. Bouldin Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 8, 1918

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Christian Kahl

14. MOTHER'S MAIDEN NAME

Agnes May Price

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

217 12 0632

17. INFORMANT

912 South Bouldin Street
Mr. John B. Mayers Jr.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/9/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3/13/67

23C. NAME OF CEMETERY OR CREMATORY

Balto. National Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

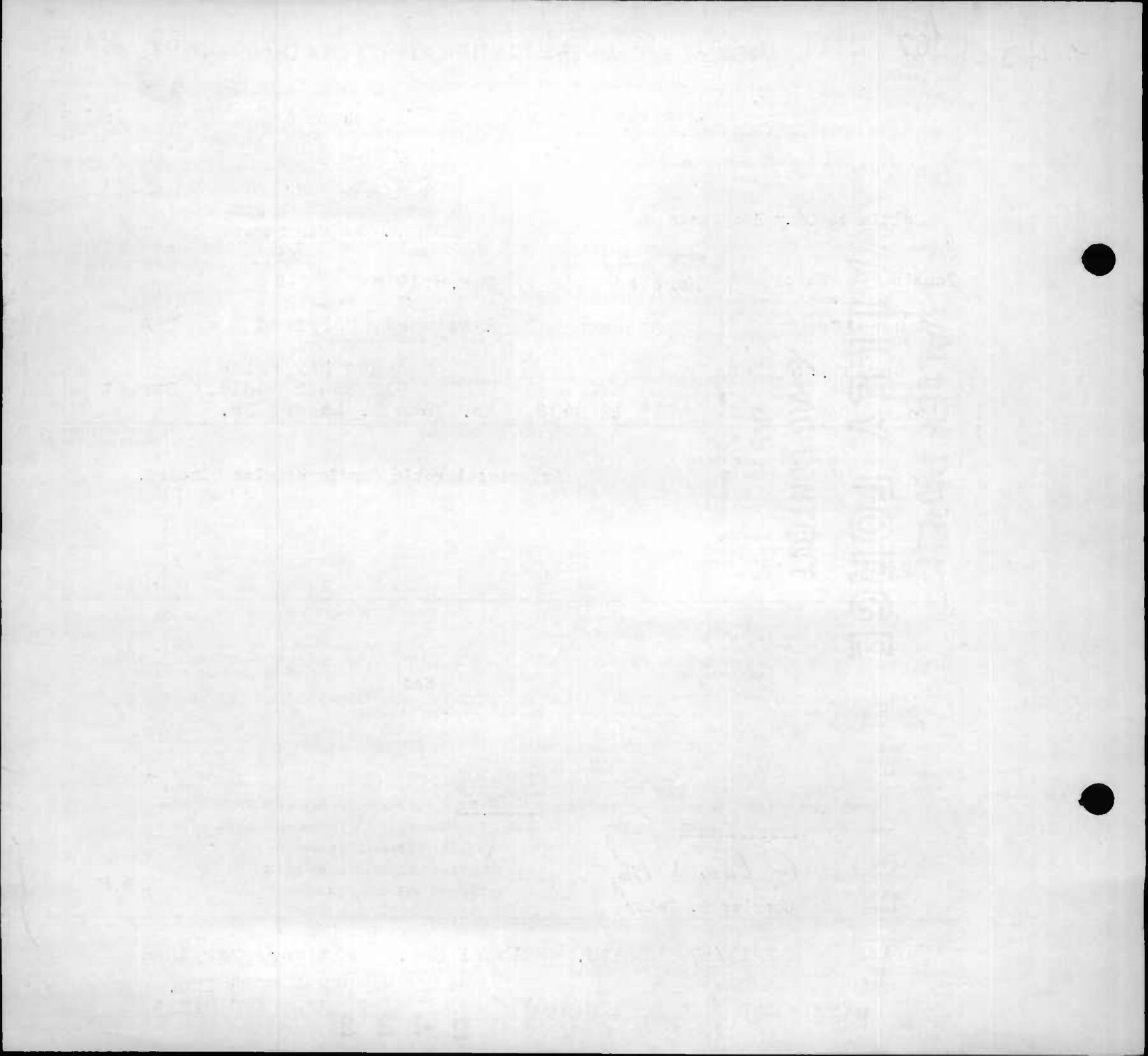
HENRY SANDER & SONS INC.

BALTIMORE, MARYLAND 21213

MAR 13 1967

Charles S. Petty

24222



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|------------------|--|----------------------------|--|--|
| BIRTH NO. 67 2415 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2415 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) (MABLE WILEN) MABEL L. WILEN | | 2. DATE AND HOUR OF DEATH 3/8/67 10:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) BALTO. CITY HOSPITALS 4940 Eastern Avenue, - 21224 | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 1/2/97 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY House Work | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA , Oxford | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME William F. LeCompte | | 14. MOTHER'S MAIDEN NAME Cynthia Kate Bayliss | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 218-18-9142 | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue, Balto. Md. 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X1 | | CAUSE OF DEATH (A) DUE TO pneumonia (B) DUE TO CVA (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 yrs. | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 4/14 19 67 to 3/8 19 67, that (I) (we) lost saw the deceased alive on 3/8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE David Swimmer | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/8/67 | |
| 23C. PHYSICIAN'S NAME (Type) DAVID SWIMMER | | 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE, BALTO., Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-11-67 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Carmel Cemetery | |
| 24D. LOCATION (City, town, or county) (State) 5712 O'Donnell St. Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR R. E. Finkbeiner | |
| 25C. FUNERAL DIRECTOR ADDRESS 901 S. Conkling St. Balto., 21224, Md. | | 25D. FUNERAL DIRECTOR Charles J. Giller | | | |

FOR THE FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2416 | |
|---|------------------|--|------------------|--|---|
| BIRTH-NO. 67 2416 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JULIUS CHARLES ORENSTEIN | | 2. DATE AND HOUR OF DEATH MARCH 8, 1967 4 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) 3304 Parklawn Ave | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 8-01 | | | |
| | | D. STREET ADDRESS (If rural, give location) 3304 Parklawn Ave. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) 67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant | | 10B. KIND OF BUSINESS OR INDUSTRY Retail | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Abraham Orenstein | | 14. MOTHER'S MAIDEN NAME Fannie ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214/32/8232 | | 17. INFORMANT ADDRESS Joseph Orenstein-- 8211 Anita Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asthma, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) DUE TO Arteriosclerotic Heart Disease (B) DUE TO Diabetes Mellitus 3/9/67 | | INTERVAL BETWEEN ONSET AND DEATH ? ? | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/2 1966 to 3/8 1967, that (I) (we) last saw the deceased alive on Sept 30 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sylvan D. Goldberg | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED March 9, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) Sylvan Goldberg | | 23D. ADDRESS M.D. Medical Arts Bldg. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/10/67 | | 24C. NAME of CEMETERY or CREMATORY RODFE ZEDEK CEMETERY | |
| 24D. LOCATION Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR R. E. Fickelmaier | | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS INC. 6010 Reist Rd. | |

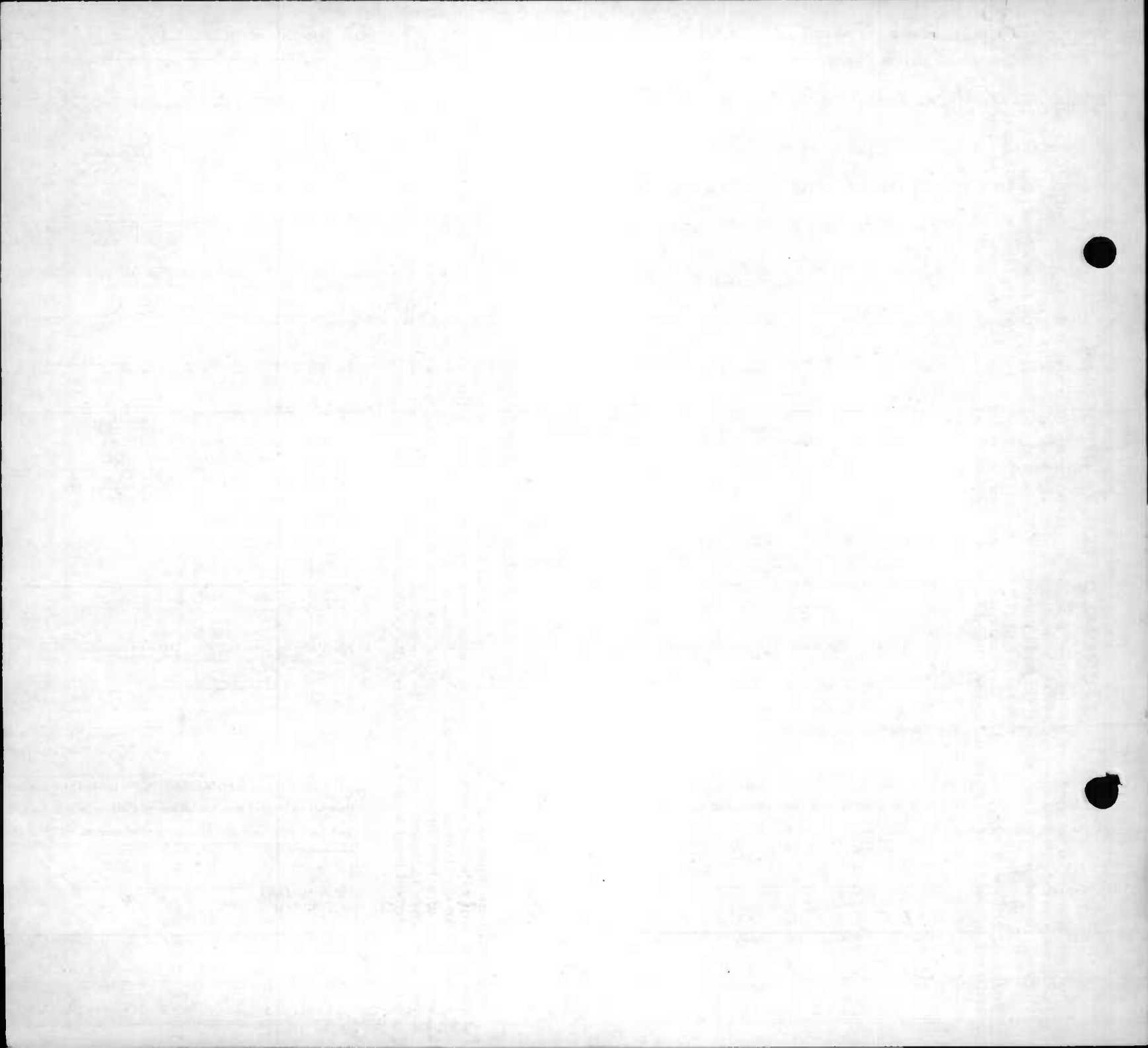
[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The" and "and" are visible.]

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

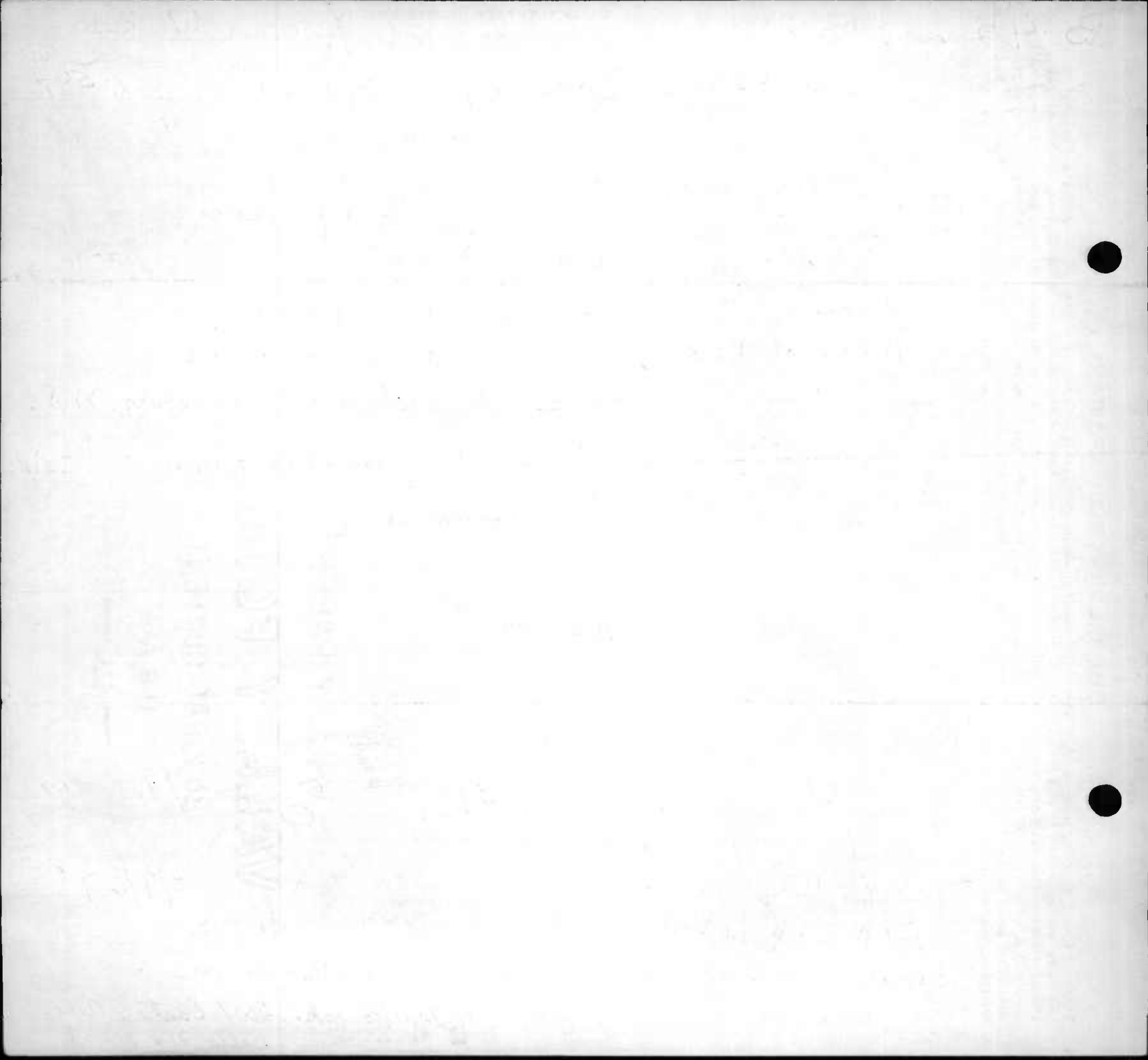
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2417</u> | |
|---|---------------------|---|---------------------------------------|---|---|
| BIRTH NO. <u>67 2417</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>ISAAC CAPLAN</u> | | 2. DATE AND HOUR OF DEATH <u>MARCH 10, 1967</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>904601 PALL MALL ROAD</u> | | D. STREET ADDRESS (If rural, give location) <u>3833 ROLAND VIEW AVE</u> | | 15-12 | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>APRIL 1987</u> | 9. AGE (In years last birthday) <u>79</u> | 10. Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>ISRAEL</u> | | 14. MOTHER'S MAIDEN NAME <u>BESSIE</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>215-01-9551</u> | | 17. INFORMANT <u>MRS YETTA CAPLAN</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <u>Coronary Embolus</u> | | CAUSE OF DEATH (A) DUE TO <u>arterio-sclerosis etc.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Dec 57</u> to <u>Mar 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 7, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Robert N. Kohman</u> | | A.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>3/11/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>LESTER N. KOHMAN MD</u> | | 23D. ADDRESS <u>7700 Park Heights Ave.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/12/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Washington Blvd</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Balto Md</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 13 1967</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Schreyer</u> | | 25C. FUNERAL DIRECTOR <u>Sylvan S. Lewis & Son</u> | | | |
| ADDRESS <u>Harrison, Md</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--|-------------------------|---|-----------------------------------|--|----------------------------|---|--|
| B-4126 | | 67 2418 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2418 | |
| CERTIFICATE OF DEATH | | | | | | | |
| BIRTH NO. 67-04835 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BLIZZARD, Baby Boy | | 2. DATE AND HOUR OF DEATH 3/9/67 1:50 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital | | (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND B. COUNTY Carroll Co. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Finksburg | |
| | | | | D. STREET ADDRESS (If rural, give location) Emory Road | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) - N.A. | 8. DATE OF BIRTH 3/8/67 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? 30/10 | |
| 13. FATHER'S NAME MELVIN BLIZZARD | | | | 14. MOTHER'S MAIDEN NAME MARION HOFF | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Melvin Blizzard - Finksburg, Md. | | | |
| 18. 773.5T DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hyaline Membrane Disease | | CAUSE OF DEATH (A) DUE TO Prematurity (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 30 hrs | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bleeding am | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 3/8 1967 to 3/9 1967 , that (1) (we) lost saw the deceased alive on 3/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Sanford Levin | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/9/67 | |
| 23C. PHYSICIAN'S NAME (Type) SANFORD LEVIN | | 23D. ADDRESS Sinai Hosp. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-10-67 | | 24C. NAME of CEMETERY or CREMATORY Holy Rosary Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR W. Fialkowski | | ADDRESS 2007 Eastern Ave. Balto. Md. 21231 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|--|--|--|---|
| BIRTH NO. 67 2419 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 67 2419 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Marlene Mary Cieslak</u> | | | 2. DATE AND HOUR OF DEATH <u>3/10/67</u> <u>3:00</u> A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>(CIESLAK)</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u> | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u> | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | |
| | | | D. STREET ADDRESS (If rural, give location) <u>2030 Bait Street</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u> | 8. DATE OF BIRTH <u>12/27/46</u> | 9. AGE (In years last birthday) <u>20</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES GIRL</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>READ'S DRUG CO.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>James Cieslak</u> | | | 14. MOTHER'S MAIDEN NAME <u>Elsie Kamosz</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Hosp. Chart</u> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>289.31 214-50-1160</u> | | | CAUSE OF DEATH <u>Pneumonia</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>72 Hrs</u> |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO <u>Cystic Fibrosis</u> | | <u>20 yrs</u> |
| (B) DUE TO | | | (C) | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input checked="" type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/8</u> 19 <u>67</u> to <u>3/10</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>W. Fialkowski</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>3/10/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>University Hospital</u> | | | | 23D. ADDRESS <u>University Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>MARCH 13, 1967</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>ST. STANISLAUS CEM.</u> | |
| 24D. LOCATION <u>BALTIMORE, MD.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 13 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fialkowski</u> | | 25C. FUNERAL DIRECTOR <u>W. Fialkowski</u> | |
| | | | | ADDRESS <u>2007 EASTERN AVE. BALTO. MD. 21231</u> | |

Complex

(C. 1900)

27. 10. 1900

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2420 | |
|---|--------------|---|----------------------------|--|--|
| BIRTH NO. 67 2420 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) FORESTELL, AGNES M. | | 2. DATE AND HOUR OF DEATH March 9, 1967, 4:50 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY Baltimore | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSP. | | D. STREET ADDRESS (If rural, give location) 3974 Edgehill Avenue #2121 | | 13-08 | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 6/7/14 | 9. AGE (In years last birthday) 52 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | 10B. KIND OF BUSINESS OR INDUSTRY University of Md. | | 11. BIRTHPLACE (State or foreign country) New York | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Patrick Bardon | | 14. MOTHER'S MAIDEN NAME Agnes Fitzpatrick | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. 025-09-3897 | | 17. INFORMANT Anna B. Hoffman-1336 W 41st ST. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Anaplastic tumor of liver DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH — weeks | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 20 MARCH 1967 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Exploratory lap | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 3, 1967 to MARCH 9, 1967. that (I) (we) lost saw the deceased alive on MARCH 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sai Rok Park | | | | 23B. DATE SIGNED MARCH 9, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) SAI ROK PARK | | | | 23D. ADDRESS BON SECOURS HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/13/67 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral | |
| 24D. LOCATION Old Frederick Rd, Md | | 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. Johnson | |
| 25C. FUNERAL DIRECTOR Address Austin E. Donovan-3818 Polansky Ave | | 25D. NAME OF REGISTRAR Robert E. Johnson | | 25E. FUNERAL DIRECTOR Address Austin E. Donovan-3818 Polansky Ave | |

Graphic series of lines

Between 1901 and 1902
Cylindrical shape
Yes

| March 2 | March 3 | March 4 | March 5 |
|-------------|-------------|-------------|-------------|
| For 2000000 | For 2000000 | For 2000000 | For 2000000 |
| X | X | X | X |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2421</u> | |
|---|---------------------|---|---|---|---|
| BIRTH NO. <u>67 2421</u> | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>Audrey C. Erdman</u> | | | 2. DATE AND HOUR OF DEATH <u>3-11-67</u> <u>3:30AM.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>North Charles General Hospital</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>13-07</u> D. STREET ADDRESS (If rural, give location) <u>3820 Roland Ave</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>12-9-03</u> | 9. AGE (In years last birthday) <u>63</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> |
| 13. FATHER'S NAME <u>George Hall</u> | | | 14. MOTHER'S MAIDEN NAME <u>Aida PATTERSON</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. — | 17. INFORMANT ADDRESS <u>JOHN B. ERDMAN - 3920 ROLAND AVE</u> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinomatosis,</u> <u>primary lesion unknown</u> | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (he) (this hospital) attended the deceased from <u>2-23</u> 19 <u>67</u> to <u>3-11</u> 19 <u>67</u> , that (I) (he) last saw the deceased alive on <u>3-10</u> 19 <u>67</u> and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (I) (he) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Neuse Hardy</u> | | | | 23B. DATE SIGNED <u>3-11-1967</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>JURI HINNO</u> | | | 23D. ADDRESS M.D. <u>5002 Frankford Ave. Bldg. 21206</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u> | | 24B. DATE <u>3/13/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Greenmount Cemetery</u> | |
| | | 24D. LOCATION (City, town, or county) (State) <u>Greenmount & Oliver St, Md</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 13 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Austin E. Donovan - 3818 Roland Ave</u> | |

1977

John A. Brown - 2220 N. 1st St.

John A. Brown - 2220 N. 1st St.

John A. Brown - 2220 N. 1st St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|--------------|--|------------------------------|---|--|
| BIRTH NO. 67 2422 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2422 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) James Howard | | 2. DATE AND HOUR OF DEATH 3/10/67 1255 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 20-01 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) 435 N. Bruce St | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 11/25/23 | 9. AGE (in years last birthday) 43 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Daniel Howard | | 14. MOTHER'S MAIDEN NAME Martha Buck | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 218-61-9304 | | 17. INFORMANT Raychell Howard 1517 Edmondson Ave | |
| 18. 445X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Uremia | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) malignant hypertension 1 yr. | | INTERVAL BETWEEN ONSET AND DEATH 3 wks | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19A. DATE OF OPERATION 2/23 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED YCS | |
| 20A. AUTOPSY? (Yes or No) YCS | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YCS | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (We) (his hospital) attended the deceased from 2/23 1967 to 3/10 1967, that (I) (we) lost saw the deceased alive on 3/10 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE Luis E. Duenya | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/10/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | |
| 24B. DATE 3/15/67 | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Banne | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|--|---|--|---|--|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2423 | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 67 2423</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>HELEN B. MATTARE</u></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <u>MARCH 7, 1967</u></p> </div> </div> | | | | | | | | | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><u>44 UNION MEMORIAL HOSPITAL</u></p> | | | | | <p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <u>MARYLAND</u></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u></p> <p>D. STREET ADDRESS (If rural, give location) <u>13-08 1421 WEIDON PLACE North</u></p> | | | | |
| <p>5. SEX <u>FEMALE</u></p> | | <p>6. RACE <u>White</u></p> | | <p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u></p> | | <p>8. DATE OF BIRTH <u>Feb. 14, 1899</u></p> | | <p>9. AGE (In years last birthday) <u>68</u></p> | |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u></p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY <u>-</u></p> | | <p>11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u></p> | | | <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p> | | |
| <p>13. FATHER'S NAME <u>William Hayes Fitez</u></p> | | | | | <p>14. MOTHER'S MAIDEN NAME <u>Minnie Routson</u></p> | | | | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p> | | | | | <p>16. SOCIAL SECURITY NO. <u>215-03-5998</u></p> | | <p>17. INFORMANT ADDRESS <u>Mrs. Helen Mildred McLaughlin 14</u></p> | | |
| <p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> <p>(A) <u>Ac. myocardial infarction</u></p> <p>(B) <u>arteriosclerotic coronary art. Dis.</u></p> <p>(C) <u></u></p> | | | | | | | | | |
| <p>19A. DATE OF OPERATION <u>4-20-71</u></p> <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>I</u></p> <p>20A. AUTOPSY? (Yes or No) <u></u></p> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u></u></p> | | | | | | | | | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u></u></p> | | | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u></p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u></u></p> | | | |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u></u></p> | | | | <p>21E. INJURY OCCURRED While At Work <u></u> Not While At Work <u></u></p> | | <p>21F. HOW DID INJURY OCCUR? <u></u></p> | | | |
| <p>22. I certify that (I) (this hospital) attended the deceased from <u>May 6 1967</u> to <u>Mar 7 1967</u>, that (I) (we) last saw the deceased alive on <u>Mar 6 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p> | | | | | | | | | |
| <p>23A. SIGNATURE <u>Edward L. Glassman</u> M.D.</p> | | | | | <p>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p> | | | <p>23B. DATE SIGNED <u>3/10/67</u></p> | |
| <p>23C. PHYSICIAN'S NAME (Type) <u>EDWARD L. GLASSMAN</u> M.D.</p> | | | | | <p>23D. ADDRESS <u>4037 Falls Rd.</u></p> | | | | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u></p> | | <p>24B. DATE <u>MAR 11 1967</u></p> | | <p>24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u></p> | | | <p>24D. LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u></p> | | |
| <p>25A. DATE REC'D BY HEALTH DEPT. <u>MAR 13 1967</u></p> | | <p>25B. NAME OF REGISTRAR <u>Robert E. Farley</u></p> | | | <p>25C. FUNERAL DIRECTOR ADDRESS <u>Burgee Funeral Home 3631 Falls Rd.</u></p> | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|----------------------|--|--|---|---|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>56-43-57</u> <u>67 2424</u> | | | | |
| BIRTH NO. <u>67 2424</u> | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>HARRIS, VIRGINIA NMN</u> | | | | | 2. DATE AND HOUR OF DEATH <u>March 8, 1967</u> <u>10¹⁵</u> A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>27-15</u> | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> 33rd & Calvert Sts. Baltimore 21218 Md. | | | | | D. STREET ADDRESS (If rural, give location) <u>1206 W. Northern pkwy.</u> | | | | |
| 5. SEX <u>F.</u> | 6. RACE <u>W.</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | | 8. DATE OF BIRTH <u>07/31/93</u> | 9. AGE (In years last birthday) <u>73</u> | 10. Under 1 Yr. Months: Days: Hours: Min. | | 11. Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>THOMAS H. WHITE</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>CATHERINE KNOTT</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>219-22-5807</u> | | 17. INFORMANT <u>Mrs. Mary S. Tillery</u> : 5723 Falls Rd. (daughter) | | | |
| 18. <u>401.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Fibrinous Pericarditis</u> <u>Bilateral Pleural effusion, Ascites</u> <u>due to</u> <u>UREMIA</u> <u>Chronic</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March 6, 1967</u> to <u>March 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 8, 1967</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Sang-Kyun Shin</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <u>March 8, 1967</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. SANG-KYUN SHIN</u> | | | | | 23D. ADDRESS M.D. <u>THE UNION MEMORIAL HOSPITAL</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY <u>Chester Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Chester town, Kent Co. Md.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 13 1967</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Burger Funeral Home</u> | | ADDRESS <u>3631 Falls Rd</u> | | | |

Fibrous Pericarditis

Bilateral Pleural Effusion, Acute

NE MIA
Continued

1
F-652

67 2425

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2425

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PATRICIA

FRANK

2. DATE AND HOUR PRONOUNCED DEAD

March 10, 1967

3:35 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5461 Cedonia Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

11/17/1935

9. AGE (In years
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

WESTERN ELECTRIC

11. BIRTHPLACE (State or foreign country)

BALTO. MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

LAWRENCE HEININGER

14. MOTHER'S MAIDEN NAME

ANNA KOCON

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ANNA SYPNIEWSKI

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Crushed Chest and Abdomen.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)
Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

6200 Blk. Pulaski Highway

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

3 10 '67 P

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver in auto-auto collision.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED
3/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

3/14/1967

23C. NAME of CEMETERY or CREMATORY

HOLY ROSARY CEMETERY BALTO.

23D. LOCATION

(City, town, or county)

MARYLAND

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 13 1967

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

JOHN M. WEBER & SONS INC. 401 S. CHESTER ST.

USA

PAUL WILKINSON

ANNA KECOL

ANNA WILKINSON

UNITED

FORGE

WILKINSON

MARRIED

WESTERN ELECTRIC

LAKESIDE HENNINGER

NO

WILKINSON

SPRING RIVER CEMENTRY CO. TO.

MADE IN

JOHN P. WILKINSON & SONS

K-242

67 2426

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2426

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOHN

KOZLOWSKI

2. DATE AND HOUR PRONOUNCED DEAD

March 9, 1967

1:14 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3422 Chesterfield Avenue

5. SEX

Male

6. RACE

Male

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

11/15/1913

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LONG SHOREMAN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO. MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JOHN KOZLOWSKI

14. MOTHER'S MAIDEN NAME

? UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

215-07-0205

17. INFORMANT

ADDRESS

MARY KOZLOWSKI 3422 CHESTERFIELD AVE

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Arteriosclerotic Cardiovascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/9/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

3/13/67

23C. NAME OF CEMETERY or CREMATORY

HOLY ROSARY CEMETERY

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE MARYLAND

24A. DATE RECEIVED BY HEALTH DEPT.

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

JOHN M. WEBER & SONS INC. 4015 CHESTER ST

Medical Examiner Release Body.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 5-30067 2427 | | | | BALTIMORE CITY | | BIRTH NO. | | M.E. CASE NO. | |
|--|--|--|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | |
| BOHN, ALMA ANNA E. | | | | 3-10-67 | | 1:55AM | | M. | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL WILKENS & CATON AVES. BALTO. 29, MD. | | | | A. STATE MD. | | B. COUNTY | | | |
| 5. SEX FEMALE | | | | 6. RACE CAUCASION | | 7. MARRIED, NEVER MARRIED WIDOWED | | 8. DATE OF BIRTH 1-30-73 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) GERMANY | | 12. CITIZEN OF WHAT COUNTRY? GERMANY USA | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN | | 16. SOCIAL SECURITY NO. UNKNOWN | |
| 17. INFORMANT Mr. Alfred E. Bohn-5102 Greenwich Gardens ST. AGNES RECORDS: WILKENS & CATON | | | | 18. CAUSE OF DEATH (A) POSS. Cerebro-vascular accident (B) POSS. Myocardial infarction (C) Severe arteriosclerosis heart disease | | 19. INTERVAL BETWEEN ONSET AND DEATH 3 dys 3 dys unknown. | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 31 19 67 to MARCH 10 19 67, that (I) (we) last saw the deceased alive on MARCH 10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | 23A. SIGNATURE J.D. Bohorquez | | 23B. DATE SIGNED 3-10-67 | | | |
| 23C. PHYSICIAN'S NAME (Type) J.D. BOHORQUEZ | | | | 23D. ADDRESS St. Agnes Hospital | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-13-67 | |
| 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR Witzke E. D. | | | | 25D. ADDRESS 4101 Edmondson Ave. | | VS 150-REV. 1/1/67 | | MAR 13 1967 | |

NOT A MEDICAL EXAMINER
CHIEF OR ASST. MEDICAL EXAMINER
Chloris E. M.D.

67 9407

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ALMA ALVA

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ALMA ALVA

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2428 | |
|--|----------------------|--|---|---|---|
| BIRTH NO. 15 IN-630 67 2428 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>Marguerite Norwood</i> | | | | 3-10-1967 6:45 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE <i>Maryland</i> B. COUNTY <i>16 05</i> | |
| <i>South Baltimore General Hosp.</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore #21216</i> | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>2300 Riggs Ave.</i> | |
| 5. SEX <i>F.</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed Divorced</i> | 8. DATE OF BIRTH <i>4-15-1897</i> | 9. AGE (In years last birthday) <i>69</i> | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Retired.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>John J. Doyle</i> | | | 14. MOTHER'S MAIDEN NAME <i>Margaret Burns.</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>216-28-4745</i> | | 17. INFORMANT ADDRESS <i>Mrs. Benedict J. Frederick 4409 Bedford Place - 21218</i> | |
| 18. <i>327.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) <i>PULMONARY INSUFFICIENCY</i> DUE TO | |
| ANTECEDENT CAUSES | | | | (B) <i>PULMONARY EMPHYSEMA</i> DUE TO | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) _____ | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES.</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that at (this hospital) attended the deceased from <i>2-23</i> 19 <i>67</i> to <i>3-10</i> 19 <i>67</i> , that we (we) last saw the deceased alive on <i>3-10</i> 19 <i>67</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Harold A. Burnham</i> M.D. | | | | 23B. DATE SIGNED <i>3-10-1967</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>HAROLD A. BURNHAM, M.D.</i> | | | | 23D. ADDRESS <i>S.B.G.H. - 1213 Light St.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3-13-67</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i> | |
| 24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i> | | (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR <i>Robert E. Jackson</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Witzke F.D.-4101 Edmondson Ave.</i> | |

RECEIVED
JAN 10 1964
U.S. AIR FORCE
HONOLULU

RECEIVED
JAN 10 1964
U.S. AIR FORCE
HONOLULU

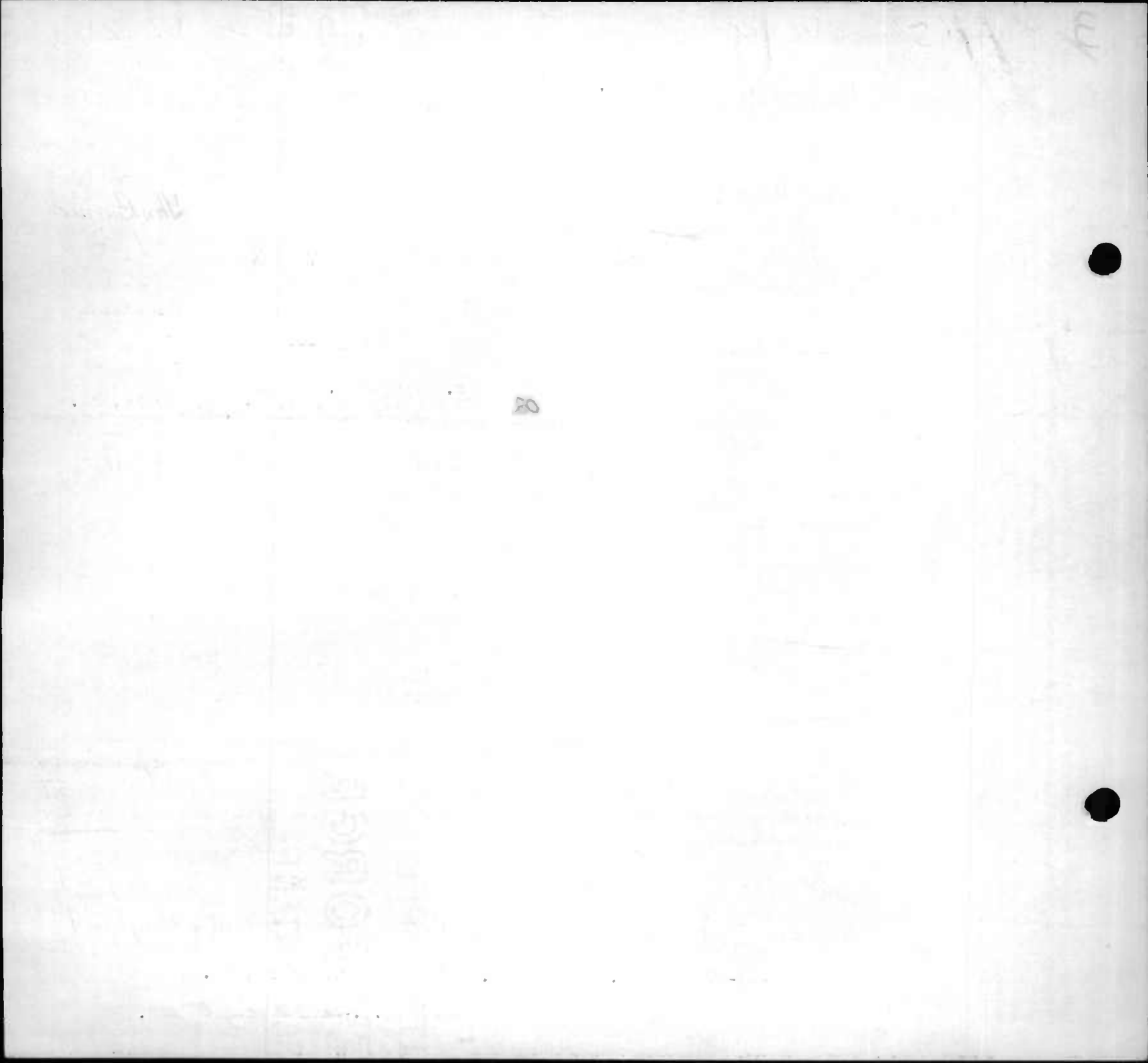
RECEIVED
JAN 10 1964
U.S. AIR FORCE
HONOLULU

RECEIVED
JAN 10 1964
U.S. AIR FORCE
HONOLULU

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | 67 2429 | |
| BIRTH NO. 67 2429 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Mehlsling, Edna C. | |
| 2. DATE AND HOUR OF DEATH March 10th 1967 11:30 PM | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland | | | A. STATE B. COUNTY 22 Country Club Dr. G. G. Co. | | |
| 5. SEX Female | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Maryland 52-00 | | |
| 6. RACE White | | | D. STREET ADDRESS (If rural, give location) 22 Country Club Dr. Glen Burnie | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | | 8. DATE OF BIRTH 10-25-1899 | | 9. AGE (In years last birthday) 67 68X |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? America | | | 13. FATHER'S NAME Charles Colburn | | |
| 14. MOTHER'S MAIDEN NAME Hattie --- | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. 212 03 9802A | | | 17. INFORMANT Mr. Raymond H. Mehlsling 22 Country Club Drive-Glen Burnie, Md. | | |
| 18. 792X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH (A) Terminal Uremia | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) DUE TO | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examined) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/20/67 19 to 3/10/1967, that (I) (we) last saw the deceased alive on 11PM 3/10/1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Nguyen Thi Oanh M.D. | | | | 23B. DATE SIGNED 3/10/67 | |
| 23C. PHYSICIAN'S NAME (Type) NGUYEN THI OANH M.D. | | | | 23D. ADDRESS Lutheran Hospital of Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-13-67 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| 25B. NAME OF REGISTRAR Robert E. Jarboe | | 25C. FUNERAL DIRECTOR Witzke F.D. 4101 Edmondson Ave. | | | |

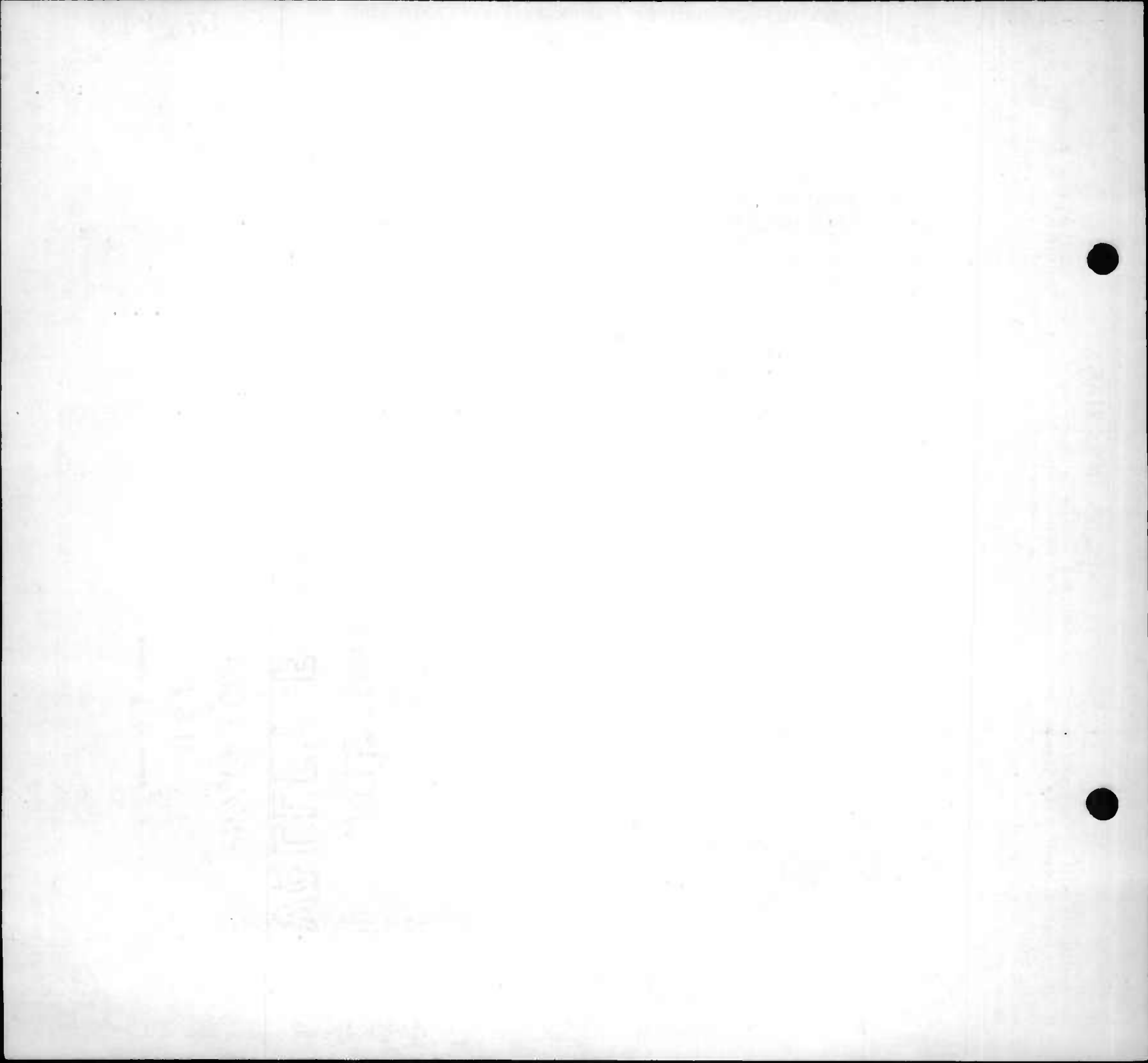


48-72-20 ED 1
F.6600

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2430 | |
|---|-------------------------|---|---|--|---|
| BIRTH NO. 67 2430 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) John Farrow H | | | 2. DATE AND HOUR OF DEATH 3/10/67 2:00A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland # 21224 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 5-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1227 E. Monument St. | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 3/87 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME Farrow | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT BCH: RECORDS 4940 Eastern Ave. Baltimore, Md. |
| 18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO Carcinoma of lung (B) DUE TO pneumonia (C) INTERVAL BETWEEN ONSET AND DEATH 1 yr. 2 days. | | | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II ASCVD ? yrs. | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/20 19 67 to 3/10 19 67 , that (I) (we) last saw the deceased alive on 3/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE David Swimmer | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/10/67 |
| 23C. PHYSICIAN'S NAME (Type) David Swimmer | | | 23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Maryland #21224 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY St. Catharine Cent | |
| 24D. LOCATION (City, town, or county) (State) Brooklyn Me | | 24E. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 24F. NAME OF REGISTRAR R. B. E. Taylor | |
| 24G. FUNERAL DIRECTOR Chas. Wilson | | 24H. ADDRESS | | 24I. DATE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2431 | |
|---|-------------------------|--|------------------------------------|--|---|
| BIRTH NO. 67 2431 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) LULA EDMONDS | | 2. DATE AND HOUR OF DEATH 3/10/67 1:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 804 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) L 1034 NORTH PATTERSON PARK AVENUE | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 4/18/87 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) N. Carolina | |
| 13. FATHER'S NAME Barrow | | 14. MOTHER'S MAIDEN NAME Barrow | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-09-6756A | | 17. INFORMANT George Harris ADDRESS SAME | |
| 18. 140.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of lip | | (A) DUE TO | | (B) DUE TO | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 2/6/67 19 to 3/10/67 19, that (I) (<u>we</u>) last saw the deceased alive on 3/10/67 19 and that in (<u>my</u>) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John Sargent MD | | 23B. DATE SIGNED 3/10/67 | | 23C. PHYSICIAN'S NAME (Type) JOHN SERGENT | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-14-67 | | 24C. NAME OF CEMETERY or CREMATORY MT. Auburn Cem. | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Chas. G. Wilson | | 25D. ADDRESS 1000 Broadway Ave. | | | |

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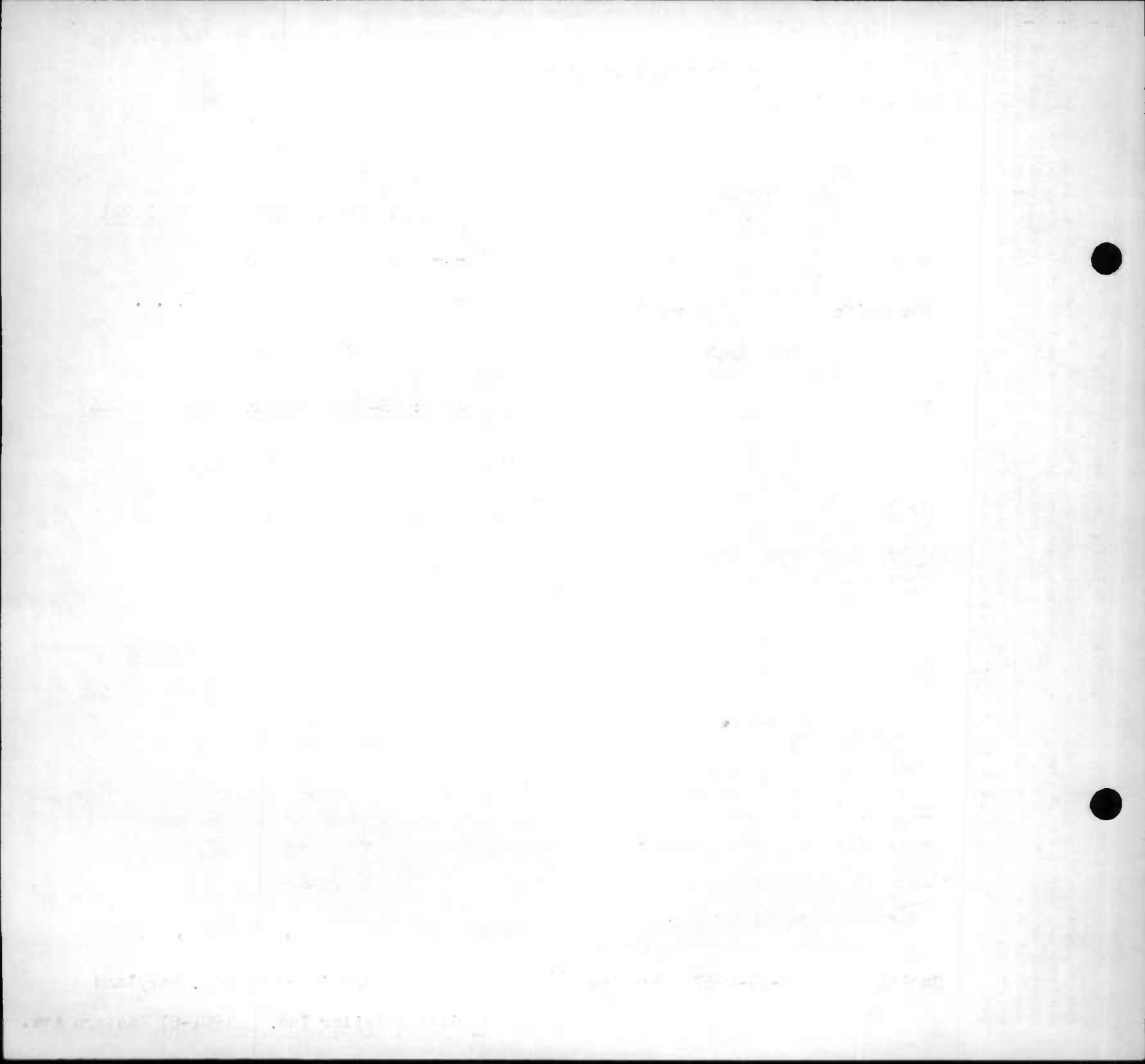
Chap. 1. White and Black

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No. 67 2432

| | | | |
|---|---------------|--|------------------------------------|
| BIRTH NO. 67 2432 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) WINIFRED MEDWICK | | 2. DATE AND HOUR OF DEATH 3/10/67 12 ¹⁵ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | A. STATE Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 638 South Ellwood Avenue 21224 | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 11-5-1888 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | 9. AGE (In years last birthday) 78 |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frank Roth | | 14. MOTHER'S MAIDEN NAME Henrietta Busch | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | ADDRESS | |
| Records: BCH-4940 Eastern Avenue | | 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | |
| ANTECEDENT CAUSES | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) pseudomonas pneumonia 3 days | |
| | | (B) chronic lung disease 10-20 yrs | |
| | | (C) | |
| II | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 3/6 to 3/10 19 67, that (1) (we) last saw the deceased alive on 3/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE David Swimmer | | 23B. DATE SIGNED 3/10/67 | |
| 23C. PHYSICIAN'S NAME (Type) David Swimmer | | 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-13-1967 | |
| 24C. NAME OF CEMETERY or CREMATORY Oak Lawn | | 24D. LOCATION Baltimore County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | |
| Lilly & Zeiler Inc. | | 1901-07 Eastern Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 67 2433 | |
|--|------------------|--|---|--|---|
| CERTIFICATE OF DEATH | | | | Registered No. | |
| BIRTH NO. 67 2433 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) ELEANOR P STOUT | | 2. DATE AND HOUR OF DEATH 3 11 67 12:15P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9.9 Co | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL 40 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21225 D. STREET ADDRESS (If rural, give location) 523 CEDAR HILL RD 52-00 | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 1 5 94 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE (Packer) | | 10B. KIND OF BUSINESS OR INDUSTRY American Sugar Co. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME CHARLES PAYNE | | | 14. MOTHER'S MAIDEN NAME SOPHIA METZ | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 212 03 0020 | | 17. INFORMANT BALTO 29 MD ST AGNES HOSP RECORDS WILKENS & CATON | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Congestive heart failure DUE TO (B) Cirrhosis of liver & ascites, severe DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) <u>this hospital</u> attended the deceased from 3 8 19 67 to 3 11 19 67, that (1) <u>we</u> last saw the deceased alive on 3 11 19 67 and that in <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>We</u> (did) <u>XXXX</u> view the body after death. | | | | | |
| 23A. SIGNATURE S. Korbuly | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/11/67 | |
| 23C. PHYSICIAN'S NAME (Type) S. KORBULY | | 23D. ADDRESS M.D. ST. AGNES HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/14/67 | | 24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. Stephens | | 25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. 24501 East Fort Avenue | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WALTER

ANDERSON

2. DATE AND HOUR PRONOUNCED DEAD

March 11, 1967

1:35 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

2103 Chdsea Terrace

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2103 Chelsea Terrace

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Divorced

8. DATE OF BIRTH

March 3, 1904

9. AGE (In years
last birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tailor

10B. KIND OF BUSINESS OR INDUSTRY

Strongwell Mfg. Co.

11. BIRTHPLACE (State or foreign country)

Lynchburg, Va.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Walter M. Anderson

14. MOTHER'S MAIDEN NAME

Archie Arrington

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

228-14-1160

17. INFORMANT

ADDRESS

David P. Anderson P.O. Box 144 Fawn Grove, Pa.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID INJURY OCCUR?
If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
3/11/6723A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

March 13, 1967

23C. NAME of CEMETERY or CREMATORY

Spring Hill Cemetery

23D. LOCATION

(City, town, or county)

Lynchburg, Va.

24A. DATE REC'D BY HEALTH DEPT.

MAR 13 1967

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks, Inc. 1217 St. Paul St.

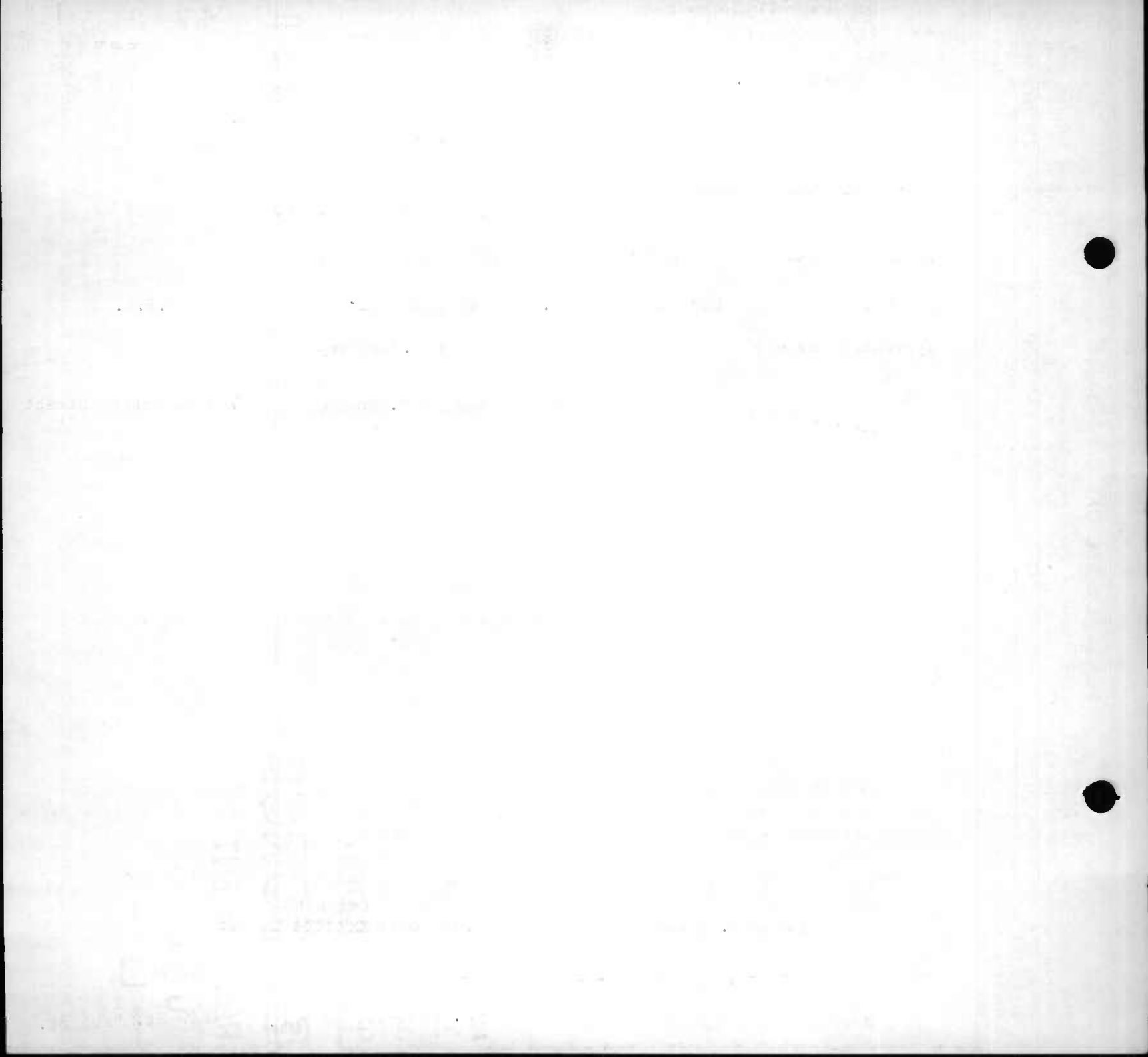
ADDRESS

VALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

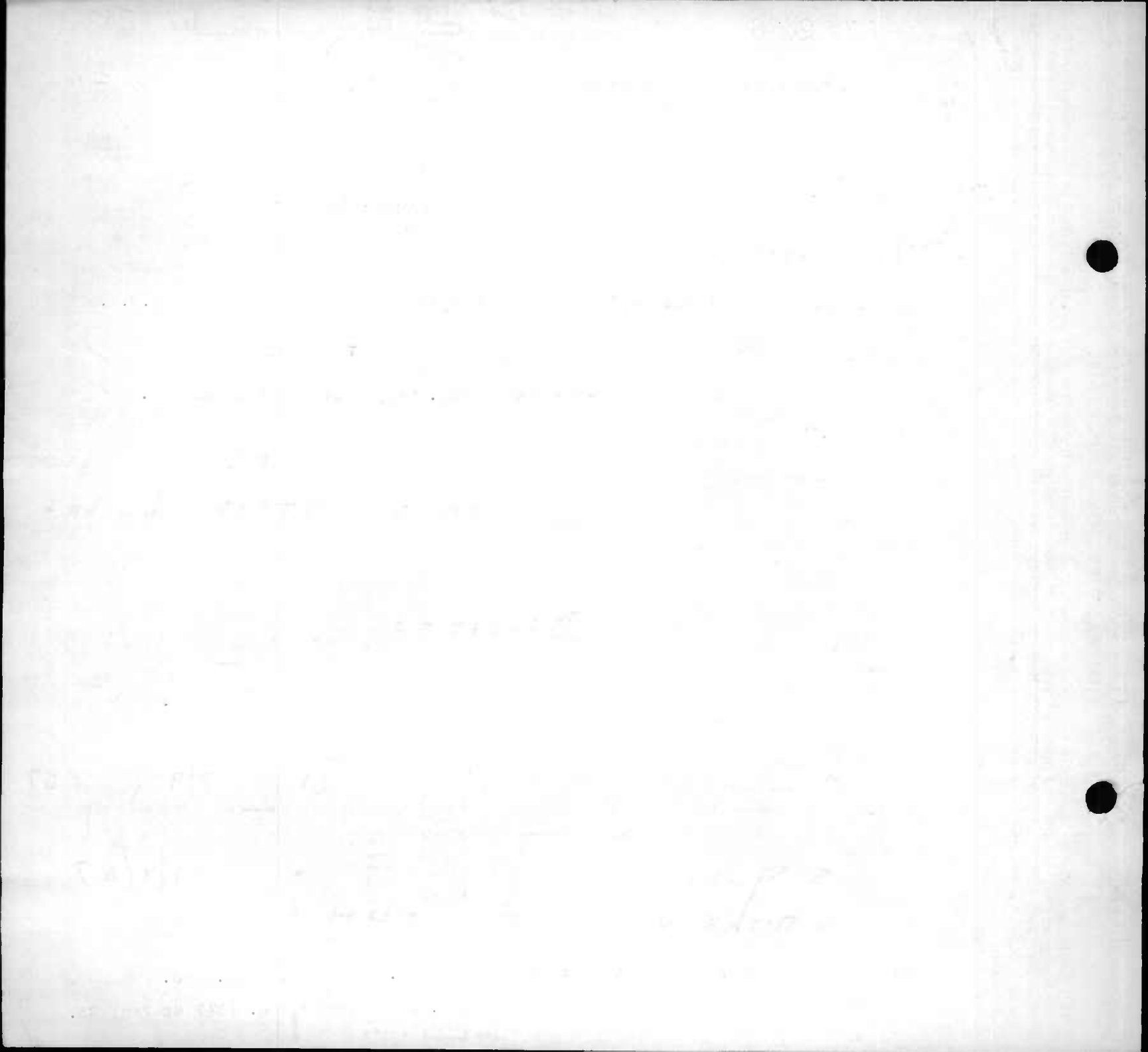
| BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | | | | | | | | |
|--|-------------------------|--|--|--|--|---|--|---|--|
| BIRTH NO. 67 2435 | | Registered No. 67 2435 | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) GRACE L. MURPHY | | | | | | 2. DATE AND HOUR OF DEATH MARCH 10, 1967 - 9:55 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Melchor Nursing Home | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 719 Homestead Street 21218 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH April 18, 1896 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor | | | | 10B. KIND OF BUSINESS OR INDUSTRY C&P Telephone Co. | | 11. BIRTHPLACE (State or foreign country) New York City | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Sylvester Russell | | | | | | 14. MOTHER'S MAIDEN NAME Annie L. Woolsey | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 212-05-1857A | | 17. INFORMANT ADDRESS Russell M. Murphy 719 Holmstead Street | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Hemorrhage - 2 days (A) DUE TO ANTECEDENT CAUSES (B) DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cardio-Vascular Disease - 2 years | | | | | | | | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1967 to March 10, 1967 , that (I) (we) last saw the deceased alive on Mar. 10, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Frank N. Ogden | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED March 11, 67 | |
| 23C. PHYSICIAN'S NAME (Type) Frank N. Ogden | | | | 23D. ADDRESS M.D. 2701 North Charles Street | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-13-67 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. | | ADDRESS 1217 St. Paul St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|---|---|--|--|
| BIRTH NO. 67 2436 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2436 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) CHARLES BROOKS | | | 2. DATE AND HOUR OF DEATH 3/8/67 11:15 AM | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital | | | A. STATE MARYLAND B. COUNTY Balts Co. | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 13 LYNBROOK ROAD | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 6/11/09 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10B. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME GEORGE W. BROOKS | | |
| 14. MOTHER'S MAIDEN NAME MARGARET CONSTANT | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. 216-01-1504 | | | 17. INFORMANT ADDRESS Mrs. Mary Bloch 13 Lynbrook Rd. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 241X1 + 260X ? POSSIBLE MI ASTHMA ATTACK few hrs | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES | | | | | |
| 19A. DATE OF OPERATION 2 - | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20A. AUTOPSY? (Yes or No) YES | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) - | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) - | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | |
| 22. I certify that (I) (the hospital) attended the deceased from 3/9 19 67 to 3/9 19 67 , that (I) was last saw the deceased alive on 3/9 19 67 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. G. Fisher S. Nishkin | | | | 23B. DATE SIGNED 3/9/67 | |
| 23C. PHYSICIAN'S NAME (Type) S. Nishkin | | 23D. ADDRESS JHH | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/13/67 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. 1217 St Paul St. | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

ADA MONTGOMERY

2. DATE AND HOUR PRONOUNCED DEAD

March 9, 1967

5:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

3014 Christopher Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

14

D. STREET ADDRESS (If rural, give location)

3014 Christopher Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

July 30, 1878

9. AGE (In years
last birthday)

88

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Benjamin

Anderson

14. MOTHER'S MAIDEN NAME

Ada Samassthe

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

236-28-5303

17. INFORMANT

Mr. Heber Culp.

ADDRESS

Same as # 4

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 10, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Mar. 13, 1967

23C. NAME OF CEMETERY or CREMATORY

Hereford Baptist Cemetery

23D. LOCATION

(City, town, or county)

Baltimore Co., Maryland

24A. DATE REC'D BY HEALTH DEPT.

MAR 13 1967

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks Towson, 1050 York Road
Towson 4, Maryland

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WASHINGTON, D. C. 20250

DATE: 10/15/78

TO: DIRECTOR, BLM

FROM: SAC, DENVER

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|--|------------------------------------|--|---|
| BIRTH NO. 67 2438 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2438 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Dennis, Mary F. (Mabel) | | 2. DATE AND HOUR OF DEATH 3-8-67 6:00 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital 34 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland - Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 7-01 O. STREET ADDRESS (If rural, give location) 618 N. Potomac St. #5 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 5-29-96 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months: Oays: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cook | | 10B. KIND OF BUSINESS OR INDUSTRY Klein's Bar | | 11. BIRTHPLACE (State or foreign country) South Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? AMERICA | | 13. FATHER'S NAME William Green | | | |
| 14. MOTHER'S MAIDEN NAME Mary Gilday | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ? no | | | |
| 16. SOCIAL SECURITY NO. 216-03-6967 | | 17. INFORMANT Roy Dennis, husband, above Hospital Chart | | | |
| 18. 4501 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Pulmonary Embolism, post bilateral (B) DUE TO Peripheral arteriosclerotic (C) occlusive disease with gangrene both feet | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2-28-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 2-29-67 to 3-8-67 , that (I) (we) last saw the deceased alive on march 8 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jorge B. Joaquin | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3-8-67 | |
| 23C. PHYSICIAN'S NAME (Type) JORGE B. JOAQUINO | | 23D. ADDRESS Bon Secours Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/13/67 | | 24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE RECD. BY HEALTH DEPT. MAR 13 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farkner | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Bretons Lane #13 | | | |

Polymyositis, not related
to the disease with
polymyositis

March 8

March 8

March 8

John B. Johnson

John B. Johnson

John B. Johnson

X

March 8

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final dispositions made.

| BIRTH NO. 67 2439 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2439 | |
|---|-------------------------|---|------------------------------------|--|--|---|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ROBINSON Elmer Robinson | | | | 2. DATE AND HOUR OF DEATH 3/10/67 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 252 North Hilton Street | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 7/11/81 | 9. AGE (In years last birthday) 85 | If Under 1 Yr. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (State or foreign country) Ind. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Edward Robinson | | | | 14. MOTHER'S MAIDEN NAME Annie ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Ridgley Robinson - 252 N. Hilton St. | | | |
| 18. 05-3,41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia, Sepsis. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 2/13 19 67 to 3/10 19 67 , that (I) (we) last saw the deceased alive on 3/10 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE W. Stan Wilson | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/10/67 | |
| 23C. PHYSICIAN'S NAME (Type) W. Stan Wilson | | | | 23D. ADDRESS JTH. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/15/67 | | 24C. NAME OF CEMETERY or CREMATORY Putty Hill | | 24D. LOCATION (City, town, or county) (State) Sullivan, Balto. Co. Ind. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR R. E. Taylor | | 25C. FUNERAL DIRECTOR Wm. H. Hartman Jr. | | ADDRESS 1701 Mt. Cullough St. Balto. Ind. | |

THE UNIVERSITY OF CHICAGO
LIBRARY

100

Chicago, Illinois

July 1

Dear Sir,

I have the pleasure to acknowledge the receipt of your letter of the 27th inst.

Very truly yours,

Wm. B. Latimer, President
The University of Chicago

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2440 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 67 2440 | |
|---|---------------------|---|--|---|---|
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Julius F. Loetz | | | 9 Mar 67 5 ⁰⁰ A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fayette Nursing Home | | | A. STATE Maryland | | |
| 90 1105 E. Fayette Street | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 2002 Casadelk Ave | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 12-23-91 | 9. AGE (In years last birthday) 75 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Man | | 10B. KIND OF BUSINESS OR INDUSTRY Balto. City Fire Dept. | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 13. FATHER'S NAME Julius Frederick Loetz | | | 14. MOTHER'S MAIDEN NAME Sophia Miller | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 218 03 6970 | | 17. INFORMANT Mr. August B. Loetz Pasadena Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cancer Lower Bowel | | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Osteoarthritis - ASCLD | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) did not attended the deceased from 12-29-1965 to 9 Mar 1967 , that (I) was last saw the deceased alive on 9 Mar 1967 and that in my my opinion death occurred on the date and hour and from the causes stated above. (I) did not (did) did view the body after death. | | | | | |
| 23A. SIGNATURE J. Hulla | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9 Mar 67 |
| 23C. PHYSICIAN'S NAME (Type) Dr. J. Hulla | | | 23D. ADDRESS M.D. 2214 E. Fayette Street 21231 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE March 11, 1967 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. Asberry | | 25C. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto. Md. | |

100

2.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 2441**

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

CARL W. RICE, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

March 9, 1967**11:26 A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)**Baltimore City Hospitals**4. USUAL
A. STATERESIDENCE (Where deceased lived. If institution: residence before admission)
B. COUNTY**Maryland**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

White Marsh 21162

D. STREET ADDRESS (If rural, give location)

Box 683, Bangert Street

5. SEX

Male

6. RACE

White7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)**Married**

8. DATE OF BIRTH

8-31-19209. AGE (In years
last birthday)**46**If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)**Engineer**

10B. KIND OF BUSINESS OR INDUSTRY

Western Electric

11. BIRTHPLACE (State or foreign country)

Cumberland12. CITIZEN OF
WHAT COUNTRY?**U.S.A.**

13. FATHER'S NAME

Carl W. Rice Sr.

14. MOTHER'S MAIDEN NAME

Emma Gross15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)**Yes****WW II**16. SOCIAL
SECURITY NO.**219-07-8592**

17. INFORMANT

ADDRESS

Mrs Elenor Rice 683 Bangert Street**420.01**

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)**(A) Arteriosclerotic Heart Disease.**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.**(B)**
DUE TO**(C)**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)**Charles S. Petty**

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/9/6723A. BURIAL CREMATION,
REMOVAL (Specify)**Burial**

23B. DATE

3-13-1967

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

MAR 13 1967

24B. NAME OF REGISTRAR

Philip E. Feltz

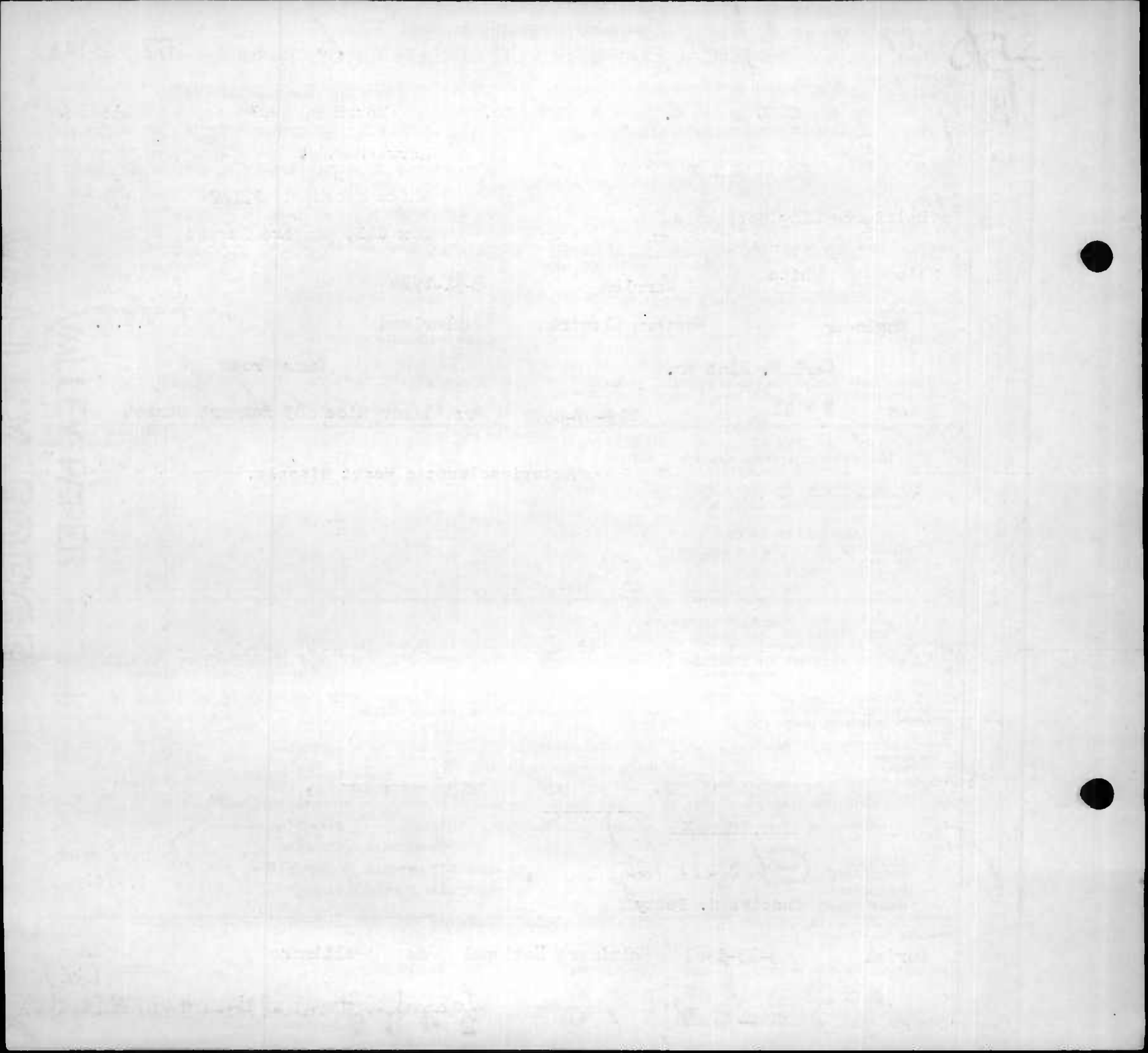
24C. FUNERAL DIRECTOR

Loughlin Funeral Home 7401 Baltimore

ADDRESS

(32)

13 d24



M.E. CASE NO.

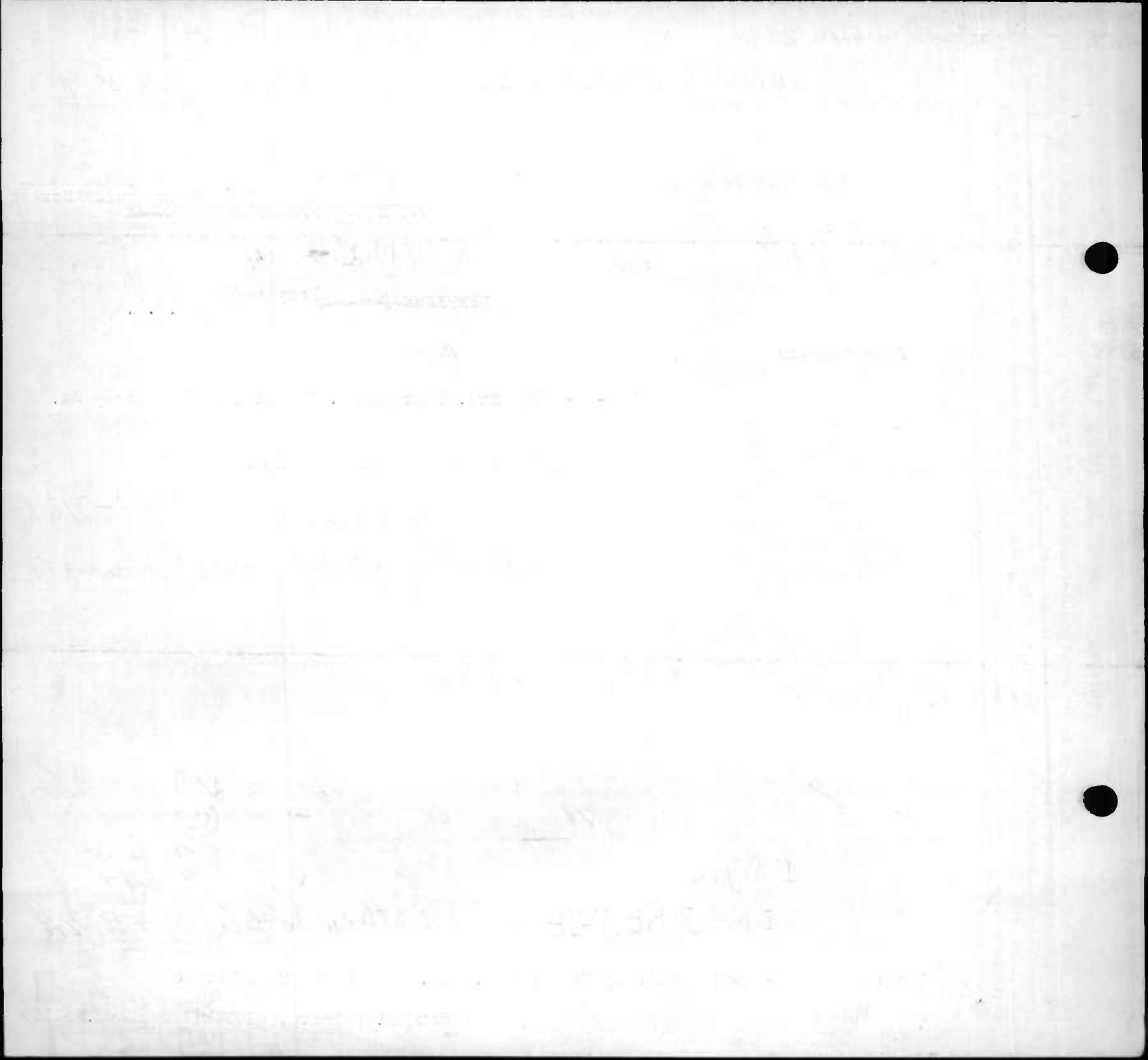
Registered No. 67-2442

VS 151-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 2443 | |
|---|-------------------------|---|--------------------------------------|---|--|---|--|
| BIRTH NO. 67 2443 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) SUMMERS, WILLIAM McKinley | | 2. DATE AND HOUR OF DEATH 3/8/67 3:25 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 46 Lutheran Hospital of Maryland | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md. B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 20-06 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 5445 Brunswick Street XXXXXX XXXXXXXX XXXXXXXX | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8/21/1902 | | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) XXXXXXXXXXXX Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Summers | | | | 14. MOTHER'S MAIDEN NAME Annie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 216-09-0670 | | 17. INFORMANT ADDRESS Mrs. Florence M. Summers, 3379 Dulaney St. | | | |
| 18. 450.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis Gangrene of toe right foot, above the knee amputation | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 3/1/67-3/8/67 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 3/6/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Above the knee amputation | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/1/67 to 3/8/67 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/8/67 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE I. Rejaie | | | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/8/67 | |
| 23C. PHYSICIAN'S NAME (Type) IRA J. REJAIE | | | | 23D. ADDRESS Lutheran Hospital of Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-11-67 | | 24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------|---|------------------|--|---|
| BIRTH NO. 67 2441 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2441 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | HEINZERLING, KEEFER G | | 2. DATE AND HOUR OF DEATH MARCH 9, 1967 9:15 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| ST. AGNES HOSPITAL CATON AND WILKENS AVENUES BALTIMORE, MD. 21229 | | MARYLAND 21227 | | Balt Co | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | |
| | | D. STREET ADDRESS (If rural, give location) | | 53.00 3600 GEORGETOWN ROAD | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days Hours Min. |
| MALE | WHITE | SINGLE | 8 - 4 - 04 | 62 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RETIRED | | RETIRED | | MARYLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| AUGUST HEINZERLING | | ANNIE BURGGRAPH | | U S A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 215-07-4460 | | ST AGNES RECORDS WILKENS & CATON AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) Myocardial Infarction, acute | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Pulmonary embolism, acute | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| O | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 3/8/67 to 3/9 19 67, that (X) (we) last saw the deceased alive on 3/9 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| S. Korbuly | | | | 3-10-67 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| S. KORBULY | | St. Agnes Hospital Caton and Wilkens | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 3-13-1967 | | Western Cemetery | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 13 1967 | | Robert E. Hubbard | | Howard H. Hubbard, 4107 Wilkens Ave. 21229 | |

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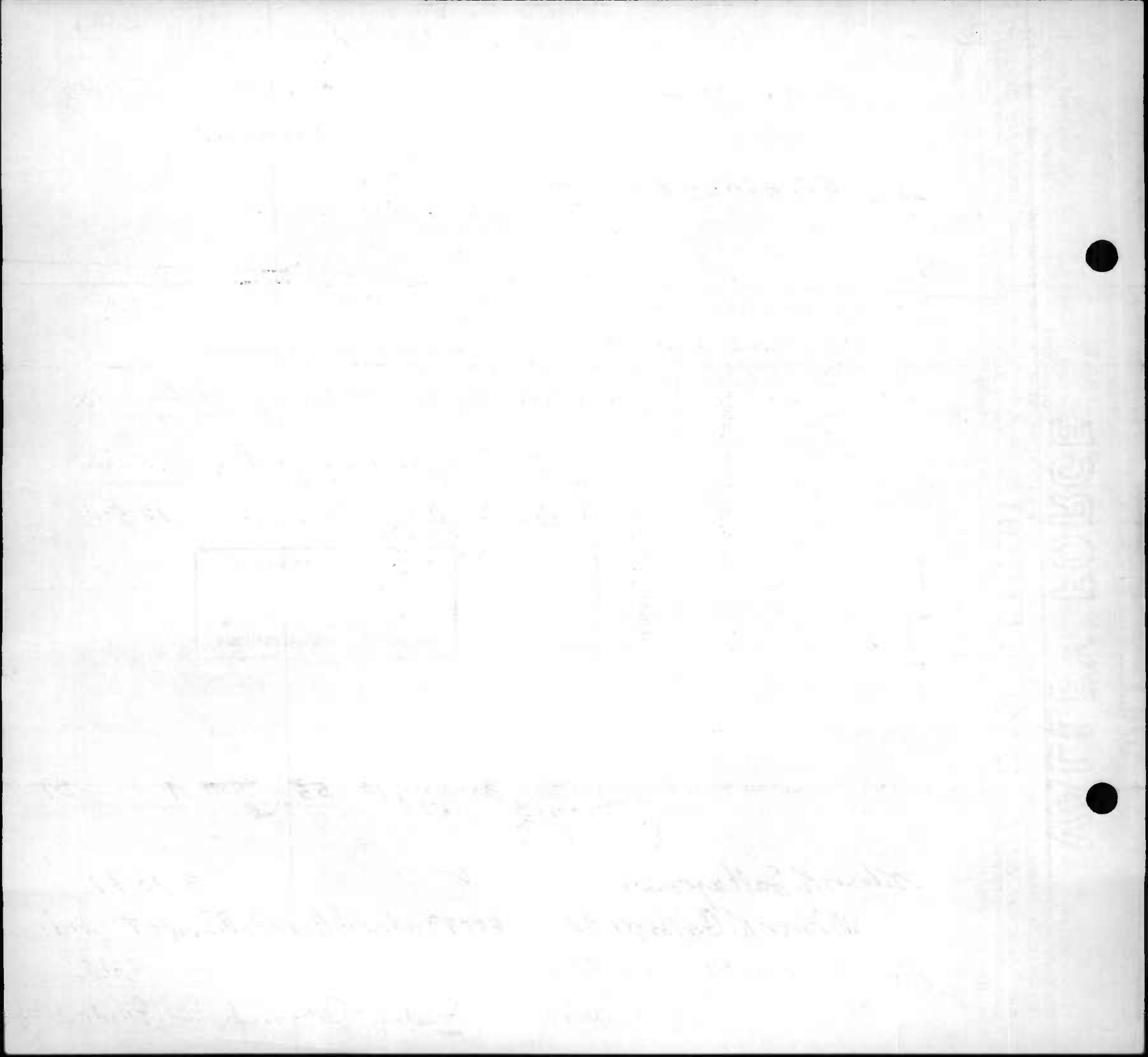
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 67 2445 | | REGISTERED NO. 67 2445 | |
|---|-------------------------|--|------------------------------------|--|---|---|--|
| M.E. CASE NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | |
| 1. NAME OF DECEASED (Type or Print) Doering, Howard E. | | | | 2. DATE AND HOUR OF DEATH March 9, 1967 7:40p M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 ST. AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY BALTIMORE Co C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore (28) D. STREET ADDRESS (If rural, give location) 16 S. Belle Grove Rd. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 2/18/07 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN-RET. | | 10B. KIND OF BUSINESS OR INDUSTRY AUTO | | 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME CHRISTIAN DOERING | | | | 14. MOTHER'S MAIDEN NAME WILHEMINA BAUMAN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-09-8290 | | 17. INFORMANT ADDRESS Mrs. Howard E. Doering - 16 S. Belle Grove Rd | | | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Acute Myocardial Infarction Coronary Artery Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | INTERVAL BETWEEN ONSET AND DEATH 15 min. 1230' | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from January 10, 1965 to Mar. 9, 1967 , that (I) (we) last saw the deceased alive on Mar. 3, 1967 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Wilmer K. Gallagher Sr. | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3-10-67 | |
| 23C. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher Sr. | | | | 23D. ADDRESS 6209 Frederick Ave. Baltimore 28 Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-13-67 | | 24C. NAME OF CEMETERY or CREMATORY Western Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | | | 25B. NAME OF REGISTRAR Robert E. Farkner | | 25C. FUNERAL DIRECTOR ADDRESS Farkner - Gavanagh 6601 Frederick Rd. | |



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67 2446

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67-00243

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2446

M.E. CASE NO.

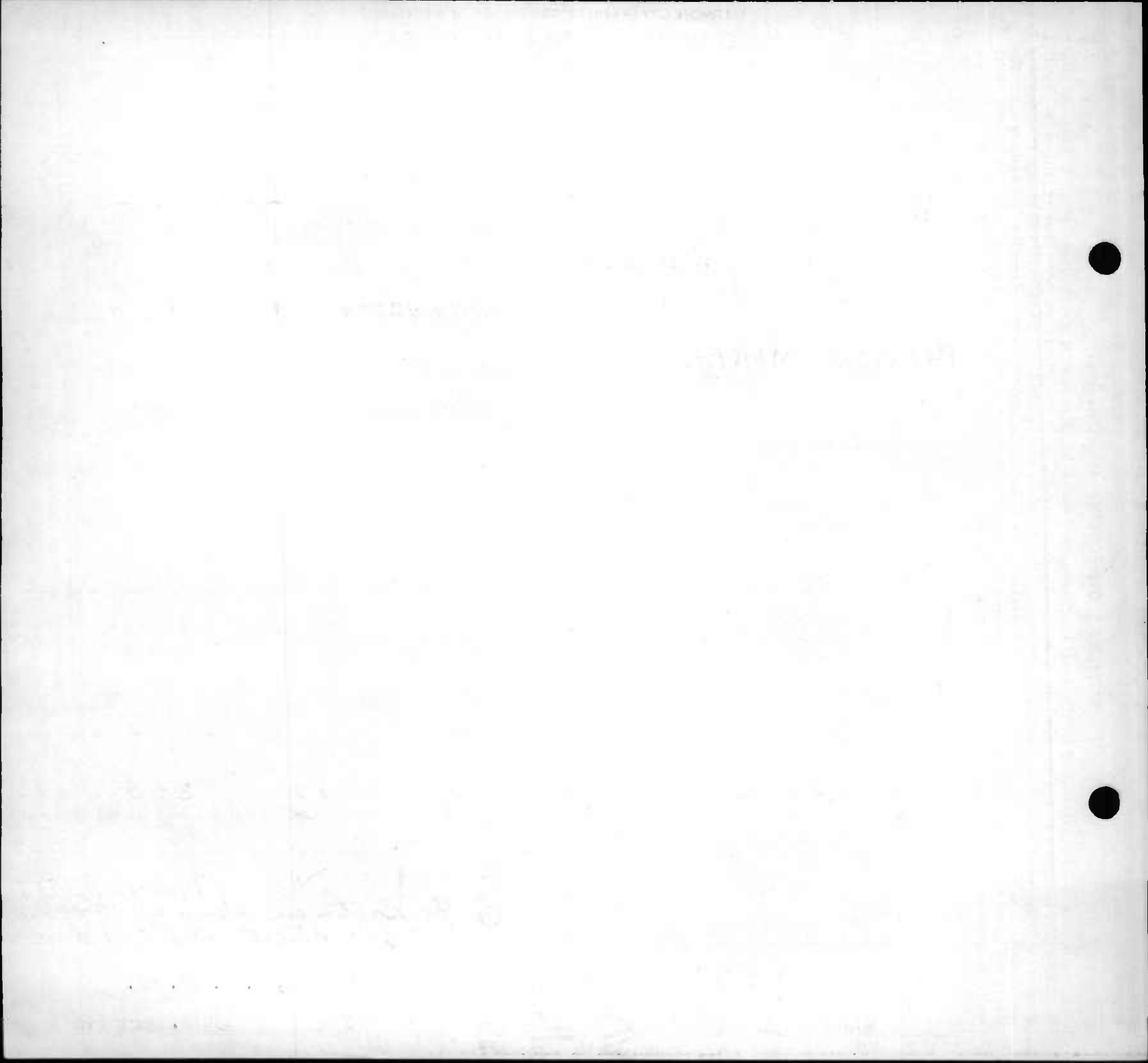
| | | | | | |
|--|------------------|---|--|--|--------------------------------------|
| 1. NAME OF DECEASED (Type or Print) | | JOHN R. LAROCHELLE | | 2. DATE AND HOUR PRONOUNCED DEAD March 12, 1967 8:55 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secour's Hospital | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-03 D. STREET ADDRESS (If rural, give location) 1902 W. Lombard Street | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | | 8. DATE OF BIRTH Jan. 3, 1967 | 9. AGE (In years last birthday) 2 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME John L. Larochelle | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE | | | | 14. MOTHER'S MAIDEN NAME ORISE ORISE BERGERON | |
| 16. SOCIAL SECURITY NO. NONE | | | | 17. INFORMANT ADDRESS John L. Larochelle 1902 W Lombard St. | |
| 18. CAUSE OF DEATH 490X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Bilateral Pneumonia. (SDII) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED 3/12/67 ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 3-13-67 | | 23C. NAME of CEMETERY or CREMATORY NEW Cathedral | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 24B. NAME OF REGISTRAR Robert E. Feltner | | 24C. FUNERAL DIRECTOR GEO. L. SCHWAB FUNERAL HOME 2101 Rudwick Ave. | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, Md. | | | | | |

ORIGINAL
DOCUMENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2447 | | | | |
| BIRTH NO. 67 2447 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>QUINN, CATHERINE G.</u> | | | | | 2. DATE AND HOUR OF DEATH <u>3-9-67</u> <u>1 40</u> P. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>43 SOUTH BALTIMORE GENERAL HOSPITAL</u> | | | | | A. STATE <u>MD.</u> B. COUNTY | | | | |
| 5. SEX <u>F.</u> 6. RACE <u>W.</u> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | | D. STREET ADDRESS (If rural, give location) <u>671 E CLEMENT ST. 330.</u> | | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | | | | 8. DATE OF BIRTH <u>7/21/82</u> | | | | |
| 11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u> | | | | | 9. AGE (In years last birthday) <u>84</u> | | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | 13. FATHER'S NAME <u>PATRICK MURPHY</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | | 16. SOCIAL SECURITY NO. | | | | |
| 17. INFORMANT <u>Family</u> | | | | | ADDRESS <u>Same</u> | | | | |
| 18. <u>331X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 dy</u> | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>poor trachea-bronchial toilet</u> | | | | | DUE TO <u>3 dy</u> | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>ASCVD</u> | | | | | DUE TO <u>3 days</u> | | | | |
| 19A. DATE OF OPERATION <u>3-9-67</u> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>spinal tap</u> | | | | |
| 20A. AUTOPSY? (Yes or No) <u>No</u> | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that <u>X</u> (this hospital) attended the deceased from <u>3-1</u> 19 <u>67</u> to <u>3-9</u> 19 <u>67</u> , that <u>X</u> (we) lost saw the deceased olive on <u>3-9</u> 19 <u>67</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Richard H. Reed</u> M.D. | | | | | 23B. DATE SIGNED <u>March 9, 1967</u> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Richard H. REED</u> M.D. | | | | | 23D. ADDRESS <u>South Baltimore General Hospital</u> <u>1213 Light Street Balto. Md. 21201</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | 24B. DATE <u>3 13 67</u> | | | | |
| 24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill</u> | | | | | 24D. LOCATION (City, town, or county) (State) <u>Brooklyn, A. A. Co. Md.</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 13 1967</u> | | | | | 25B. NAME OF REGISTRAR <u>Robert E. Farkas</u> | | | | |
| 25C. FUNERAL DIRECTOR <u>Mc Cully</u> | | | | | ADDRESS <u>130 E. Fort Ave</u> | | | | |



BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2448

BIRTH NO. 67 2448

M.E. CASE NO.

| | | | |
|---|-------------------------|--|-----------------------------------|
| 1. NAME OF DECEASED (Type or Print) VOGEL H. HELMHOLZ | | 2. DATE AND HOUR PRONOUNCED DEAD March 9, 1967 8:40 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 110 Churchwarden's Road | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 27-12 D. STREET ADDRESS (If rural, give location) 110 Churchwarden's Road | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 9-5-86 |
| 9. AGE (In years last birthday) 80 | | 10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mfg. Rep. | | 10B. KIND OF BUSINESS OR INDUSTRY Leather | |
| 11. BIRTHPLACE (State or foreign country) Wisconsin | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Augustus Helmholtz | | 14. MOTHER'S MAIDEN NAME Elizabeth C. Vogel | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 1 | | 16. SOCIAL SECURITY NO. 216-18-3028 | |
| 17. INFORMANT Elsie H. Helmholtz | | ADDRESS Above | |
| 18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease. (A) DUE TO (B) DUE TO (C) DUE TO II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 23B. DATE 3-13-67 | |
| 23C. NAME of CEMETERY or CREMATORY Greenmount | | 23D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 24B. NAME OF REGISTRAR H. W. Jenkins & Sons Co. | |
| 24C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. | | ADDRESS 4905 York Rd. Balto., Md. | |

WALLING-FRONT

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

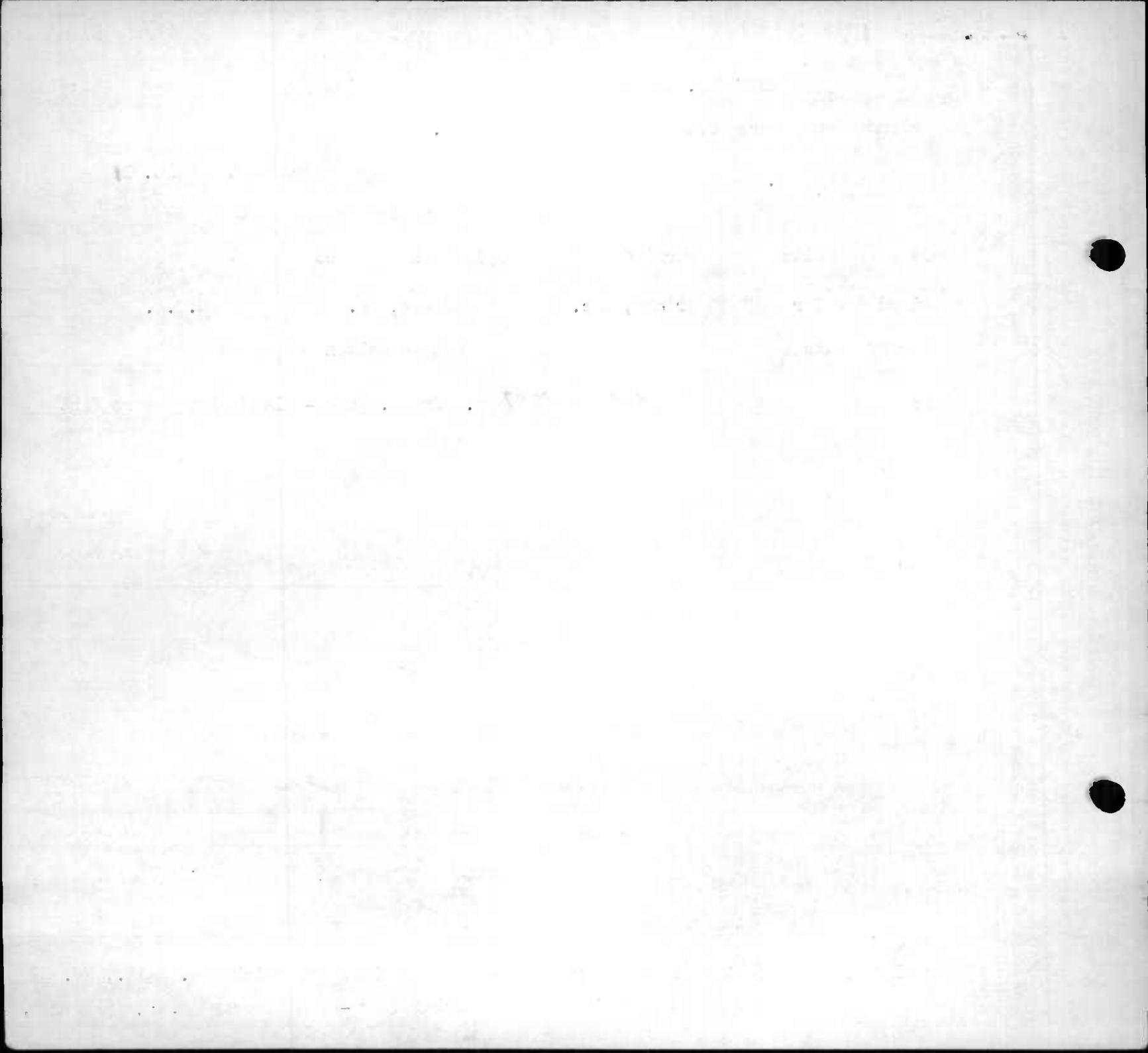
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---|--|--|--|--|---|---|---|---|-----------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2449 | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 67 2449</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) William A. Sehlhorst</p> </div> <div> <p>2. DATE AND HOUR OF DEATH March 11, 1967 1:00 P.M.</p> </div> </div> | | | | | | | | | | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>33 THE JOHNS HOPKINS HOSPITAL</p> | | | | | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE MARYLAND, BALTIMORE Co.</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) MONKTON</p> <p>D. STREET ADDRESS (If rural, give location) 53-00</p> | | | | | |
| <p>5. SEX MALE</p> | | <p>6. RACE WHITE</p> | | <p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED</p> | | <p>8. DATE OF BIRTH 12-19-95</p> | | <p>9. AGE (In years, lost birthday) 71</p> | | |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive-Retired</p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY Insurance</p> | | <p>11. BIRTHPLACE (State or foreign country) Maryland</p> | | | <p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p> | | | |
| <p>13. FATHER'S NAME RICHARD SEHLHORST</p> | | | | | <p>14. MOTHER'S MAIDEN NAME CATHERINE ROEDER</p> | | | | | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p> | | | | <p>16. SOCIAL SECURITY NO. 215-07-8168</p> | | <p>17. INFORMANT Mrs. Jean P. Sehlhorst</p> | | | <p>ADDRESS (Same)</p> | |
| <p>18. 162.11</p> <p>CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Anemia</p> | | | | | | | | | | |
| <p>19A. DATE OF OPERATION 0</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No) Yes NO</p> | | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | | | | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | | | | | | |
| <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p> | | <p>21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work At Work</p> | | <p>21F. HOW DID INJURY OCCUR?</p> | | | | | | |
| <p>22. I certify that (1) (this hospital) attended the deceased from March 10 19 67 to March 11 19 67, that (1) (we) last saw the deceased alive on March 11 19 67 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (1) (did not) view the body after death.</p> | | | | | | | | | | |
| <p>23A. SIGNATURE Joseph Silva M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p> | | | | | | | | <p>23B. DATE SIGNED March 11, 1967</p> | | |
| <p>23C. PHYSICIAN'S NAME (Type) JOSEPH SILVA M.D.</p> | | | | | <p>23D. ADDRESS The Johns Hopkins Hospital</p> | | | | | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p> | | <p>24B. DATE 3/14/1967</p> | | <p>24C. NAME OF CEMETERY or CREMATORY Loudon Park</p> | | <p>24D. LOCATION (City, town, or county) (State) Baltimore, Md.</p> | | | | |
| <p>25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967</p> | | <p>25B. NAME OF REGISTRAR Robert E. Finkbeiner</p> | | <p>25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</p> | | | | | | |

AV-12 H93206

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2450 | |
|--|-------------------------|---|--|--|---|
| BIRTH NO. 67 2450 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) NORMAN R. MEEKS | | | 2. DATE AND HOUR OF DEATH 3/10/67 4:56am. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND Roland View Towers East <small>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</small> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Roland View Towers East Balt. 16 | | |
| | | | D. STREET ADDRESS (If rural, give location) Roland View Towers East 13-07 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1/14/1901 | 9. AGE (In years last birthday) 66 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cashier | | 10B. KIND OF BUSINESS OR INDUSTRY Brinks, Inc. | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Harvey Meeks | | | 14. MOTHER'S MAIDEN NAME Lottie Galton | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-10-2747 | 17. INFORMANT Mrs. Edna A. Meeks-Roland View Towers East | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 414X I | | | CAUSE OF DEATH (A) Rheumatic endocarditis DUE TO (B) Myocardial infarction DUE TO (C) Chronic myocardial failure | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | INTERVAL BETWEEN ONSET AND DEATH 30 years 5 years ago 10 mos. | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION now | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 2/11 19 67 to March 10 19 67 , that (I) (we) last saw the deceased alive on 2/24 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles Stewart MD | | | | 23B. DATE SIGNED 3/10/67 | |
| 23C. PHYSICIAN'S NAME (Type) C. Wilbur Stewart | | | | 23D. ADDRESS 6 E. Road SE Baltimore Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/13/67 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park | |
| 24D. LOCATION (City, town, or county) (State) 3801 Frederick Ave. Balt., Md. 29 | | 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown, | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. | |
|---|------------------|---|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | 67 2451 | |
| BIRTH NO. 67 2451 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Samuel Clayton Hinkel | | | | 2. DATE AND HOUR OF DEATH 3/9/67 9:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital 33 | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY BALTIMORE Co. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Randlesstown 53-00 D. STREET ADDRESS (If rural, give location) 3421 Barry Paul Rd. | | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH 2-2-17 | | 9. AGE (In years last birthday) 50 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | | 11. BIRTHPLACE (State or foreign country) Phila., Pa. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | | | | 10B. KIND OF BUSINESS OR INDUSTRY Republic Steel | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME SAMUEL HINKLE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 071-10 2635 | | 17. INFORMANT Mrs. Martha A. Hinkel-Apt. 103 | | ADDRESS Barry Paul Rd. Randallstown | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Stroke | | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | | |
| 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 3/9/67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/6 to 3/9 1967 that (I) last saw the deceased alive on 3/9 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Rubb H. H. H. | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/9/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) Rubb H. H. H. | | | | | | 23D. ADDRESS M.D. JHH JOHNS HOPKINS HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/13/67 | | 24C. NAME OF CEMETERY or CREMATORY Lake View Memorial | | | | 24D. LOCATION (City, town, or county) (State) Liberty Rd. Carroll Co. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | | | 25B. NAME OF REGISTRAR Robert E. Johnson | | | | 25C. FUNERAL DIRECTOR Loring Evers | | | |
| ADDRESS 18728 Liberty Rd. Randallstown | | | | | | | | | | | |

RECEIVED NOV 10 1964

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|---------------------------|---|--|--|---|--|--|--|--|
| BIRTH NO. 67 2452 | | | | | CERTIFICATE OF DEATH | | | Registered No. 67 2452 | |
| 1. NAME OF DECEASED (Type or Print) <i>Bertha M. Tillman</i> | | | | | 2. DATE AND HOUR OF DEATH <i>March 8, 1967 2:05 P.M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>2663 W. North Ave.</i> | | | | | A. STATE <i>Maryland</i> B. COUNTY | | | | |
| (If not in hospital or institution, give street address or location) | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>2663 W. North Ave.</i> | | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>Colored</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Divorced</i> | 8. DATE OF BIRTH <i>May 11, 1909</i> | 9. AGE (In years last birthday) <i>57</i> | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTH PLACE (State or foreign country) <i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME <i>George Ford</i> | | | 14. MOTHER'S MAIDEN NAME <i>Florance Jones</i> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <i>215-14-9095</i> | | 17. INFORMANT <i>Mrs. Mary Bryan 3302 Ridmont Ave</i> | | | | |
| 18. 42001 | | | CAUSE OF DEATH <i>A.S.H.D. = decompensated</i> | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) DUE TO <i>Conjunctive Failure</i> | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO <i>after severe bout</i> | | | | (C) <i>of Pneumonitis - peristens (approximately)</i> | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>N/A</i> | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? <i>N/A</i> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>10/37</i> 1966 to <i>3/7</i> 1967, that (I) (we) last saw the deceased alive on <i>3/7</i> 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Uthman Lay Jr.</i> | | | | | | 23B. DATE SIGNED <i>3/9/67</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>UTMAN LAY JR.</i> | | | | | | 23D. ADDRESS <i>2225 W. North</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | 24B. DATE <i>3/11/67</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Westport (Baltimore) Md.</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 13 1967</i> | | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | | 25C. FUNERAL DIRECTOR <i>Joseph L. Jones</i> | | | |
| | | | | | | ADDRESS <i>2222 W. North Ave.</i> | | | |

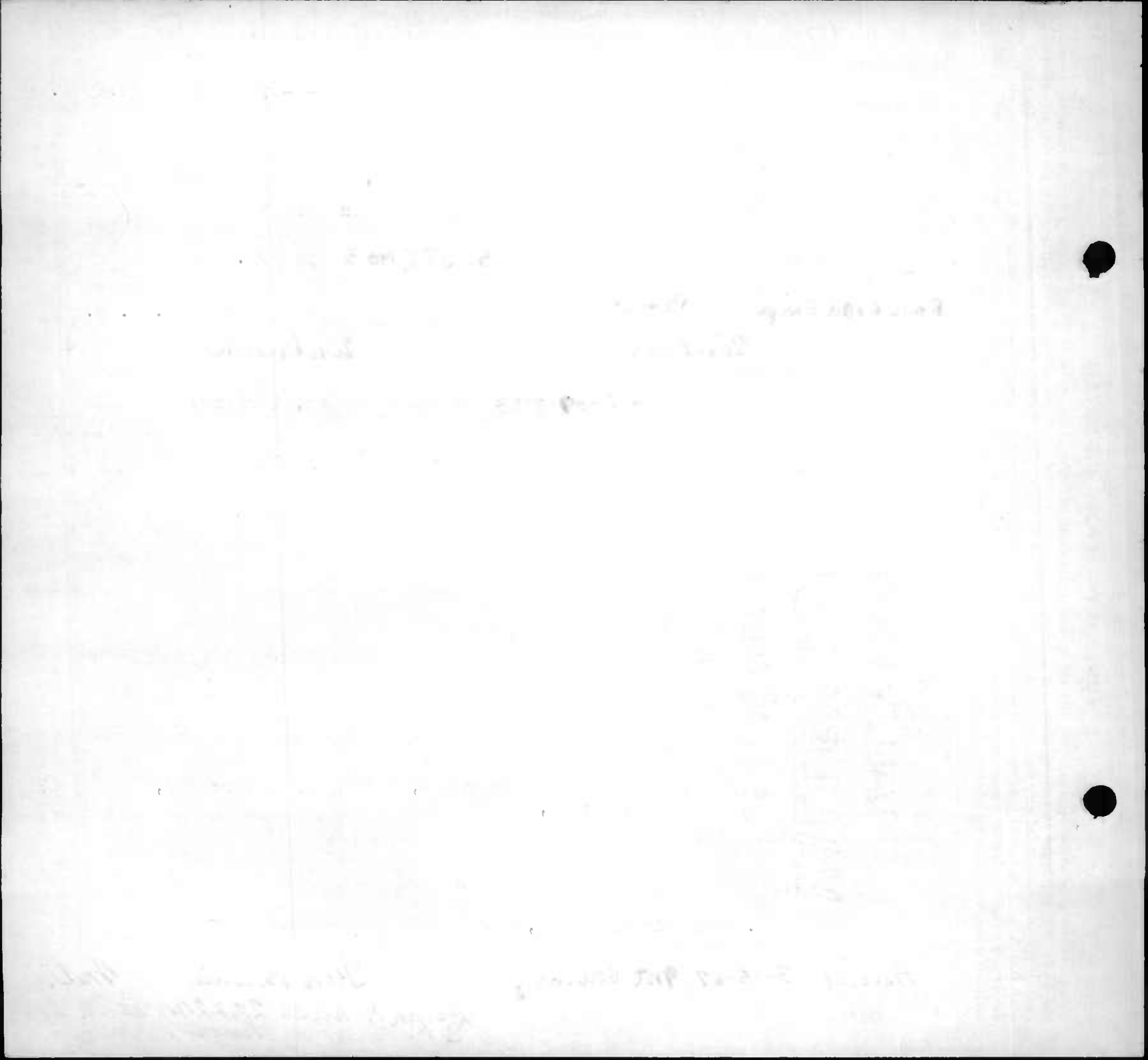
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Cooperativa Fabrice
after some time
of investigation -
(approximate)

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2453 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2453 | |
|---|------------------|---|----------------------------------|--|----------------------------|--|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) James McNeal | | | | 2. DATE AND HOUR OF DEATH 3-9-67 4:45 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 14-02 D. STREET ADDRESS (If rural, give location) 505 McMechen Street | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH Sept 8, 1903 | 9. AGE (In years last birthday) 59 yrs. | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rail Road Emph. | | 10B. KIND OF BUSINESS OR INDUSTRY B+O | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-c9-3133 | | 17. INFORMANT Howard Robinson, (Friend) | | ADDRESS SAME | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Generalized Arteriosclerosis DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 6 mths 2 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from March 9, 1967 to March 9, 1967, that (I) (we) lost saw the deceased alive on March 9, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE G. Franklin Phillips, M.D. | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/9/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS 5589 Madison St. Balto. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-15-67 | | 24C. NAME OF CEMETERY or CREMATORY Mt Calvary | | 24D. LOCATION (City, town, or county) (State) Alex Burnie Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR R. E. Taylor | | 25C. FUNERAL DIRECTOR Joseph E. Russ 2222 W. North Ave. Balto., Md. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|-----------------------------------|--|---|--|----------------------------|
| 67 2454 | | CERTIFICATE OF DEATH | | 67 2454 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | MINNIE SAWINSKI | | 3-10-67 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE | | B. COUNTY | |
| 216 N. MADEIRA ST. | | MARYLAND | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | |
| | | D. STREET ADDRESS (If rural, give location) | | 216 N. MADEIRA ST. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days |
| F | W | MARRIED | 8-29-1895 | 71 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| SEAMSTRESS | | POLAND | U.S.A. | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| SZALAPSKI | | UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 220-05-2589 | | M. Stephen Sawinski - 216 N. Madeira St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | if 18 | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | Vitamin Deficiency | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from | | May-9-1967 to May-10-1967 | | | |
| that (I) (we) last saw the deceased alive on | | May-9-1967 and that in (my) (our) opinion death occurred on the date | | | |
| and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| WM. G. GEYER | | 156 N. MILTON AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| BURIAL | 3-13-67 | OAK LAWN CEM. | BALTO. MD. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| MAR 13 1967 | W. G. Geyer | C. E. Geyer - 2534 | | Jefferson St. | |

21st March 1912

21st March 1912

21st March 1912

21st March 1912

21st March 1912

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21st March 1912

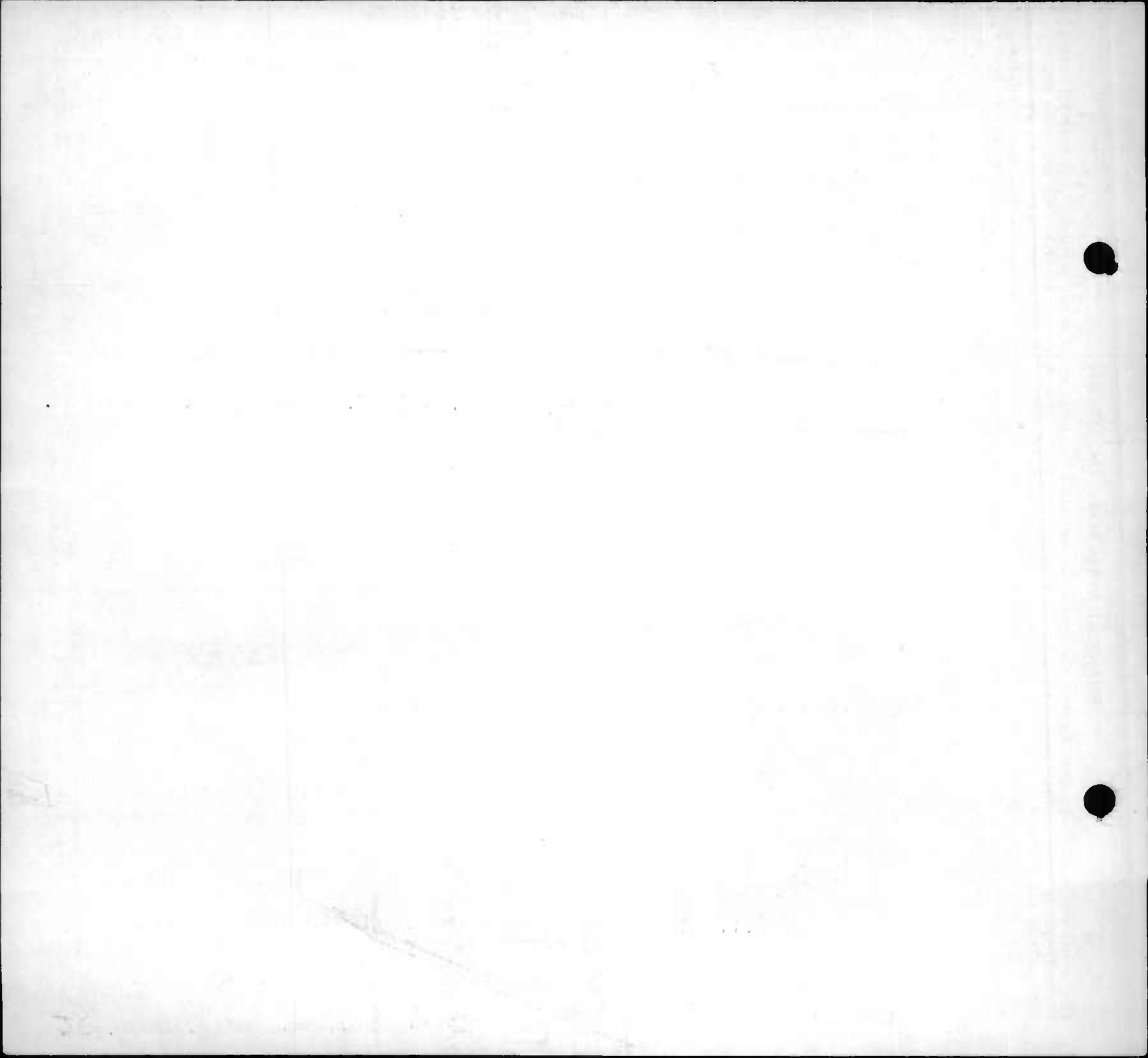
21st March 1912

21st March 1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2455 | |
|--|-------------------------|--|------------------------------------|---|---|
| BIRTH NO. 67 2455 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) EDWARD WEAVER | | 2. DATE AND HOUR OF DEATH 3/12/67 2⁰⁰ A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNSHOPKINS HOSPITAL 33 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 138 N. POTOMAC STREET 21224 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED MARRIED | 8. DATE OF BIRTH 1-13-84 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Weaver, Joseph A. | | 14. MOTHER'S MAIDEN NAME Ada Richardson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW 1 | | 16. SOCIAL SECURITY NO. 220-03-4573 | | 17. INFORMANT ADDRESS Mrs. Alice L. Weaver 138 N. Potomac St. | |
| 18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) fulm embolus MI (B) ASLD, pneumonia (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 3/8 19 67 to 3/12 19 67 , that (I) (we) last saw the deceased alive on 3/12 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE F. I. BEIGI | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/12/67 | |
| 23C. PHYSICIAN'S NAME (Type) F. I. BEIGI | | 23D. ADDRESS THE JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/16/67 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | | |
| 25B. NAME OF REGISTRAR R. B. BEIGI | | 25C. FUNERAL DIRECTOR ADDRESS John A. Moran, Inc. 3000 E. Balto., St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2456 | |
|--|-----------------------------|---|---|--|---|
| BIRTH NO. 67 2456 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) WALLACE, James Franklin | | | 2. DATE AND HOUR OF DEATH March 5, 1967 11:10 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 27 Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1332 N. Calhoun Street | | |
| 5. SEX Male | 6. RACE Negroid | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH 3/19/1896 | 9. AGE (In years lost birthday) 70 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Cook | | 10B. KIND OF BUSINESS OR INDUSTRY Fishing Vessell | 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Wallace | | | 14. MOTHER'S MAIDEN NAME Mary Moore | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 9/24/17 to 7/19/19 | | 16. SOCIAL SECURITY NO. 212-14-9998A | 17. INFORMANT Records ADDRESS V.A. Hospital Baltimore, Md. 21218 | | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized Peritonitis DUE TO Carcinoma of Esophagus with Preformation | | | INTERVAL BETWEEN ONSET AND DEATH several min. 24 hrs. 6 mo | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 2/11/67 to 3/5 19 67 , that (X) (we) last saw the deceased alive on 3/5/67 19 67 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) view the body after death. | | | | | |
| 23A. SIGNATURE Crile Crisler | | | | 23B. DATE SIGNED March 6, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) Crile Crisler | | 23D. ADDRESS 3900 Loch Raven Boulevard VA Hospital, Baltimore, Maryland 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 3/10/67 | 24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Herbert E. Nutter | | 25C. FUNERAL DIRECTOR ADDRESS 3035 W. North Ave. | |

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BIRTH NO.

67 2457

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

67 2457

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GERALD D. PEEL

2. DATE AND HOUR PRONOUNCED DEAD

March 10, 1967 8:00 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

38 University Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Frederick 60-11

D. STREET ADDRESS (If rural, give location)

403 South Market Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

October 31, 1948

9. AGE (in years
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)
Carpenter Apprentice10B. KIND OF BUSINESS OR INDUSTRY
None

11. BIRTHPLACE (State or foreign country)

Leetsdale, Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Paul W. Peel

14. MOTHER'S MAIDEN NAME

Elizabeth Fraley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
No16. SOCIAL
SECURITY NO.
218-50-2689

17. INFORMANT

ADDRESS

Mr. Paul W. Peel 403 S. Market St. Fred. Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cerebrocranial injuries
DUE TOANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)
street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Centre Street & Catocin
Avenue, Frederick, Maryland 60-1121D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
3/9/67 5:07 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Motorcycle Driver in
motorcycle - auto collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 10, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal-Burial

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Sewickley, Pennsylvania

24A. DATE REC'D BY HEALTH DEPT.

MAR 13 1967

24B. NAME OF REGISTRAR

Robert E. Fraley, M.D.

24C. FUNERAL DIRECTOR

Robert E. Dailey & Son Frederick, Maryland

ADDRESS

VALLEY FORGE

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "VALLEY FORGE" are visible vertically on the left.]



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 2458 | |
|---|----------------------|---|--------------------------------|--|--|---|--|
| BIRTH NO. 67 2458 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) AXLEY, Howard William | | 2. DATE AND HOUR OF DEATH March 9, 1967 7:40 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 996 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Maryland City D. STREET ADDRESS (If rural, give location) 325 Brockbridge Road | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1/3/09 | 9. AGE (In years last birthday) 58 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer | | 10B. KIND OF BUSINESS OR INDUSTRY Newspaper | | 11. BIRTHPLACE (State or foreign country) Gas City, Kansas | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Asa Axley | | | | 14. MOTHER'S MAIDEN NAME Hattie Nicholson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8/19/50 - 9/11/52 | | 16. SOCIAL SECURITY NO. 550-36-55-24 | | 17. INFORMANT VA Hospital Records ADDRESS 3900 Loch Raven Blvd., Balto., Md 21218 | | | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of the Esophagus DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 1 year | | | | | | | |
| 18. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cor Pulmonale Obstructive Emphysema | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from November 8th 19 67 to March 9th 19 67 , that (I) (we) last saw the deceased alive on March 9th 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Barry N. Rosenbaum M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED March 9, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) BARRY ROSENBAUM | | | | 23D. ADDRESS VA Hospital 3900 Loch Raven Boulevard, Balto., Md 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-11-1967 | | 24C. NAME of CEMETERY or CREMATORY Congressional | | 24D. LOCATION (City, town, or county) (State) Washington, D.C. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR Robert E. Fink | | 25C. FUNERAL DIRECTOR Robert A. Mattingly | | ADDRESS 131-117 St. Wash | |

MAR 13 1967

George H. Buchanan

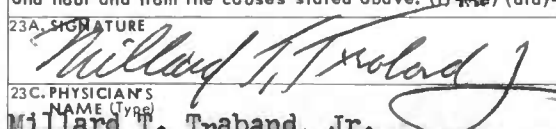
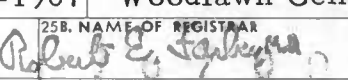
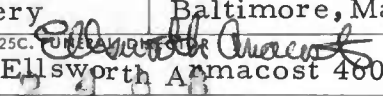
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 67 2459 | |
|--|-------------------|---|--|--|------------------------------------|--|--|
| BIRTH NO. 67 2459 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type name) | | 2. DATE AND HOUR OF DEATH | |
| | | | | Theodore Anthony Bowinkelman | | 3/12/67 6:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital 44 | | | | A. STATE Md | | | |
| | | | | B. COUNTY Baltimore City | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 9-05 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 933 Gorsuch Avenue | | | |
| 5. SEX M | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | | 8. DATE OF BIRTH 9/5/89 | 9. AGE (In years last birthday) 77 | 10. Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co. | | 11. BIRTHPLACE (State & foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Theodore Bowinkelman | | | | 14. MOTHER'S MAIDEN NAME Anna Liberhausen | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 23-10-0977 | | 17. INFORMANT Mrs. Dorothy Maccida (same) | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E916.01 3rd Degree Burns Back 2 Months | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO 3rd Degree Burns Back 2 Months | | | |
| | | | | (B) Aspiration Pneumonia 2nd To Debilitation | | | |
| | | | | (C) From above | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 933 GORSUCH AVE. 9-05 | | | |
| 21D. TIME OF INJURY (APPROX.) 1-8-67 5AM | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? CLOTHING CAUGHT FIRE FROM GAS STOVE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1/8/67 to 3/12/67, that (I) (we) last saw the deceased alive on 3/12/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Charles H. Classen Jr. | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/12/67 | |
| 23C. PHYSICIAN'S NAME (Type) DR. CHARLES H. CLASSEN JR. | | | | 23D. ADDRESS THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/15/1967 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral | | 24D. LOCATION Baltimore, Maryland | |
| 25A. DATE RECEIVED BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | ADDRESS 4905 York Rd. Balto. 12, Md. | |

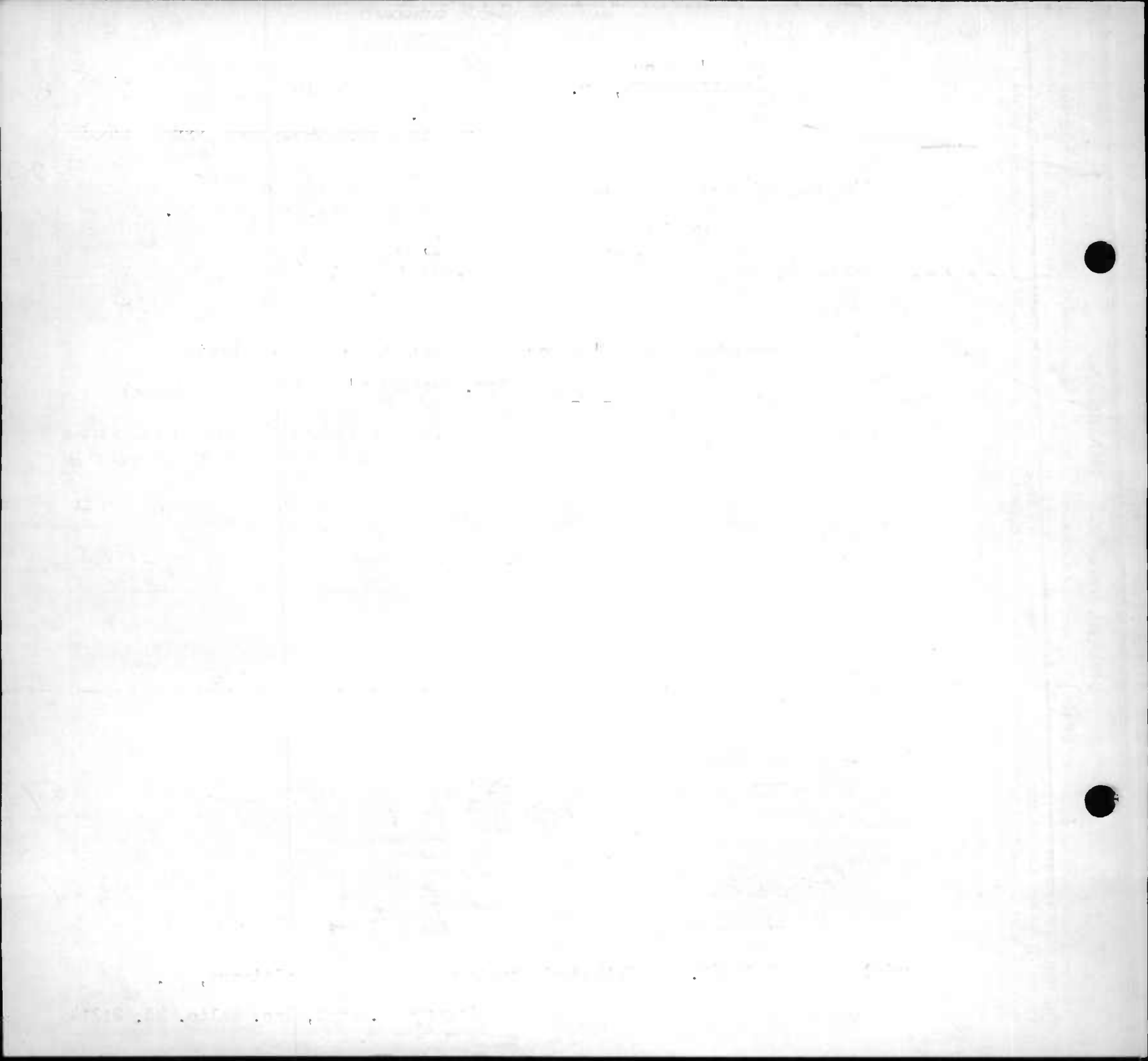
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPT. CERTIFICATE OF DEATH | | | | | | | | | |
|--|-------------------------|--|--|---|--|---|--|--|--|
| BIRTH NO. 67 2460 | | Registered No. 67 2460 | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Gertrude P. Naylor | | | | | 2. DATE AND HOUR OF DEATH 3-10-1967 6:30 A: M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Anderson Nursing Home | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 3901 Dorchester Road | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married | | 8. DATE OF BIRTH 8-13-1885 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXX Self Employed | | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Stephen Thomas Naylor | | | | | 14. MOTHER'S MAIDEN NAME Clara Cordelia Paine | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 214-34-4250 | | 17. INFORMANT ADDRESS A Katharine H. Ermer -5207 Belleville Ave | | | |
| 18. CAUSE OF DEATH | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO Ruptured abdominal aorta (aneurism) | | | INTERVAL BETWEEN ONSET AND DEATH 2 years | |
| | | | | | (B) DUE TO disease Arteriosclerotic cardiovascular | | | 5 years | |
| | | | | | (C) _____ | | | _____ | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | Uremia, chronic | | | 2 years | |
| 19A. DATE OF OPERATION ***** | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ***** | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ***** | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ***** | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ***** | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) ***** | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) ***** | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> ***** | | | 21F. HOW DID INJURY OCCUR? ***** | | | | |
| 22. I certify that (I) did not attended the deceased from August 19 65 to March 19 67 , that (I) was last saw the deceased alive on March 9, 19 67 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death. | | | | | | | | | |
| 23A. SIGNATURE  Millard T. Traband, Jr. | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 11 March 1967 | |
| 23C. PHYSICIAN'S NAME (Type) Millard T. Traband, Jr. | | | | | 23D. ADDRESS 1811 North Rolling Road, Baltimore, Md. 21207 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-13-1967 | | 24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR  | | | 25C. FUNERAL HOME ADDRESS  Ellsworth Amacost 4600 Liberty Hghts. Ave | | | | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------------------|---|------------------------------------|---|--|
| BIRTH NO. 67 2461 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2461 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>John P. O'Connor, Jr.</u> | | 2. DATE AND HOUR OF DEATH <u>3/10/67</u> <u>4:05 P.M.</u> | |
| 3. PLACE OF DEATH <u>IN BALTIMORE, MARYLAND</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE, MD</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY HOSPITAL</u> | | D. STREET ADDRESS (If rural, give location) <u>1626 NORTHWICK Rd.</u> | | E. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE, MD</u> | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED <u>Married</u> | 8. DATE OF BIRTH <u>1/24/92</u> | 9. AGE (In years last birthday) <u>75</u> | 10. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>NEWS POST</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u> | |
| 13. FATHER'S NAME <u>John P. O'Connor</u> | | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH Lewis</u> | | 15. Was <u>Deceased</u> Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW 1</u> | |
| 16. SOCIAL SECURITY NO. <u>215-10-8854</u> | | 17. INFORMANT <u>Mrs. Susanna O'Connor</u> | | ADDRESS (Same) <u>WIFE</u> | |
| 18. <u>422.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>BILATERA PNEUMONIA</u> <u>ACUTE ENCEPHALOMALACIA</u> | | CAUSE OF DEATH (A) DUE TO <u>THROMBOSIS @ MIDDLE CEREBRAL ARTERY</u> (B) DUE TO <u>ASCUTINE</u> (C) DUE TO | | INTERVAL BETWEEN DEATH AND <u>1 MONTH</u> <u>1 MONTH</u> <u>YEARS</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>3/10/67</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>2/17</u> 19 <u>67</u> to <u>3/10</u> 19 <u>67</u> . that (I) <u>(we)</u> last saw the deceased alive on <u>3/10</u> 19 <u>67</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> view the body after death. | | | | | |
| 23A. SIGNATURE <u>F. H. COST MD</u> | | 23B. DATE SIGNED <u>3/10/67</u> | | 23C. PHYSICIAN'S NAME (Type) <u>F. H. COST</u> | |
| 23D. ADDRESS <u>MERCY HOSPITAL</u> | | 23E. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> | | 23F. ADDRESS <u>BALTIMORE, MD.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/14/67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | 24E. DATE REC'D BY HEALTH DEPT. <u>MAR 13 1967</u> | | 24F. NAME OF REGISTRAR <u>R. E. Feltner</u> | |



43-23-35 1B

R-54367 2462

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 67 2462

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ALPHA K. REYNOLDS

2. DATE AND HOUR OF DEATH

3-12-67

3:30 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

2004 HILLENWOOD ROAD #21214

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

3-11-01

9. AGE (In years
last birthday)

66

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

Brewery

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

BENJAMIN Reynolds

14. MOTHER'S MAIDEN NAME

RENA DAVIS

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

214-01-9349

17. INFORMANT

#21224

ADDRESS

RECORDS-BCH-4940 EASTERN AVENUE

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

uremia

(B) DUE TO

(C)

rheumatoid arthritis

INTERVAL BETWEEN ONSET AND DEATH

2 weeks

20 yrs.

10 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

tuberculosis

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1/25/67 19 to 3/12/67 19, that (I) (we) last saw the deceased alive on 3/12/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Bruce M. Dow

M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

3/12/67

23C. PHYSICIAN'S NAME (Type)

Bruce M. Dow

M.D.

23D. ADDRESS

#21224
BCH 4940 EASTERN AVENUE

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3/15/67

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven Cemetery

24D. LOCATION (City, town, or county) (State)

Glenburnie, Md.

25A. DATE REC'D BY HEALTH DEPT.

MAR 13 1967

25B. NAME OF REGISTRAR

Robert E. Farley

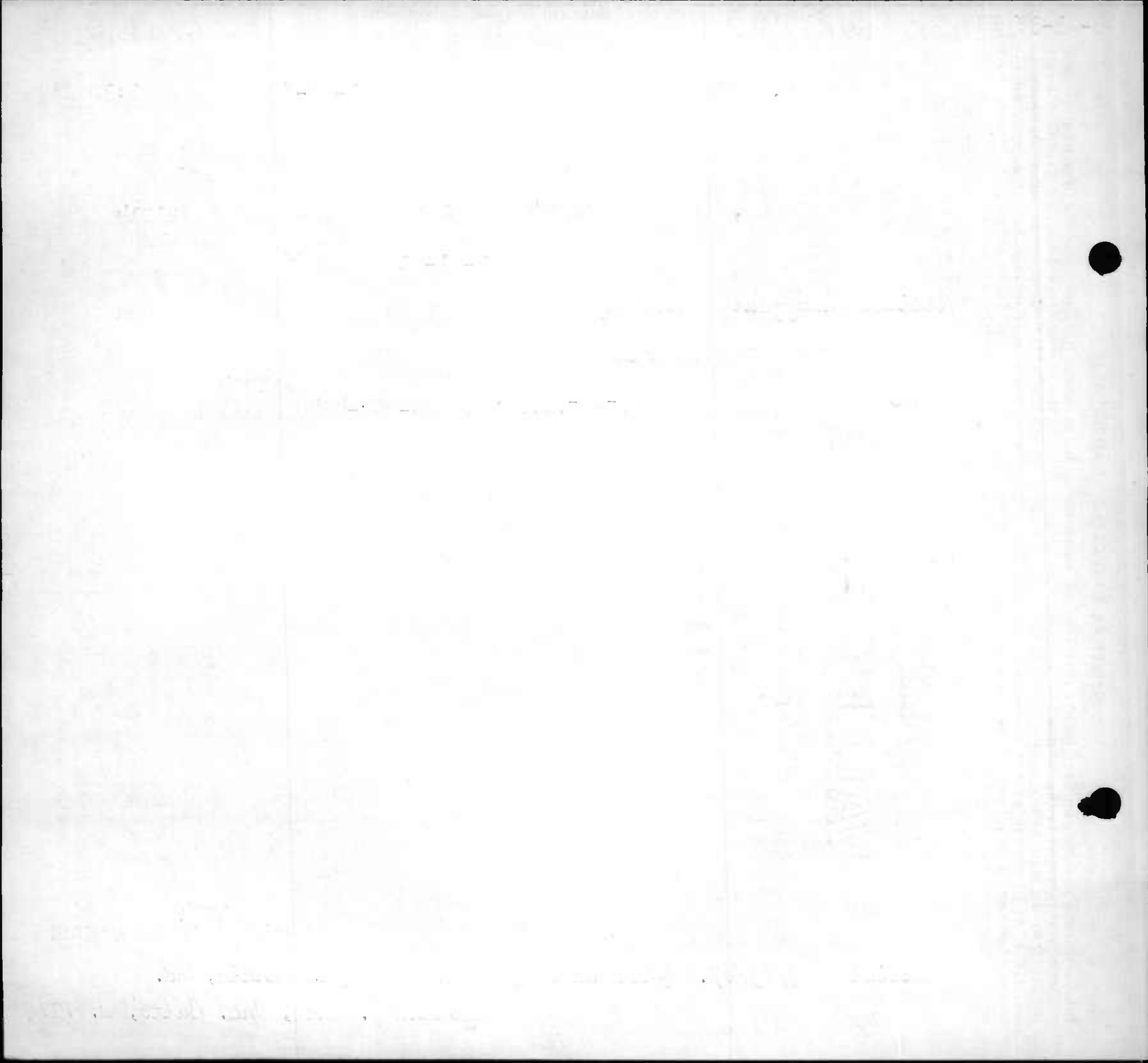
25C. FUNERAL DIRECTOR

Leonard J. Ruck, Inc. Balto, Md. #21214

ADDRESS

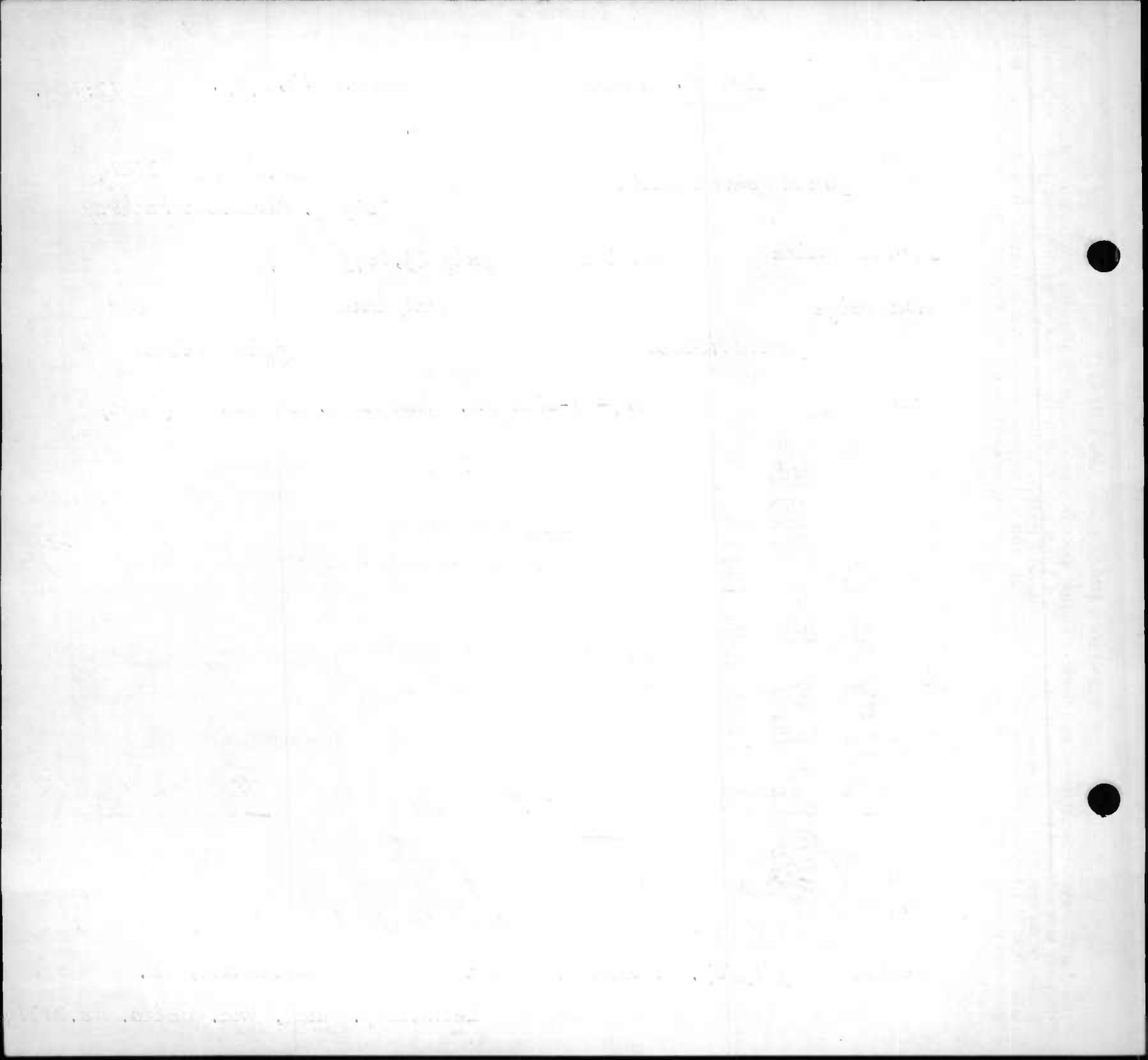
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

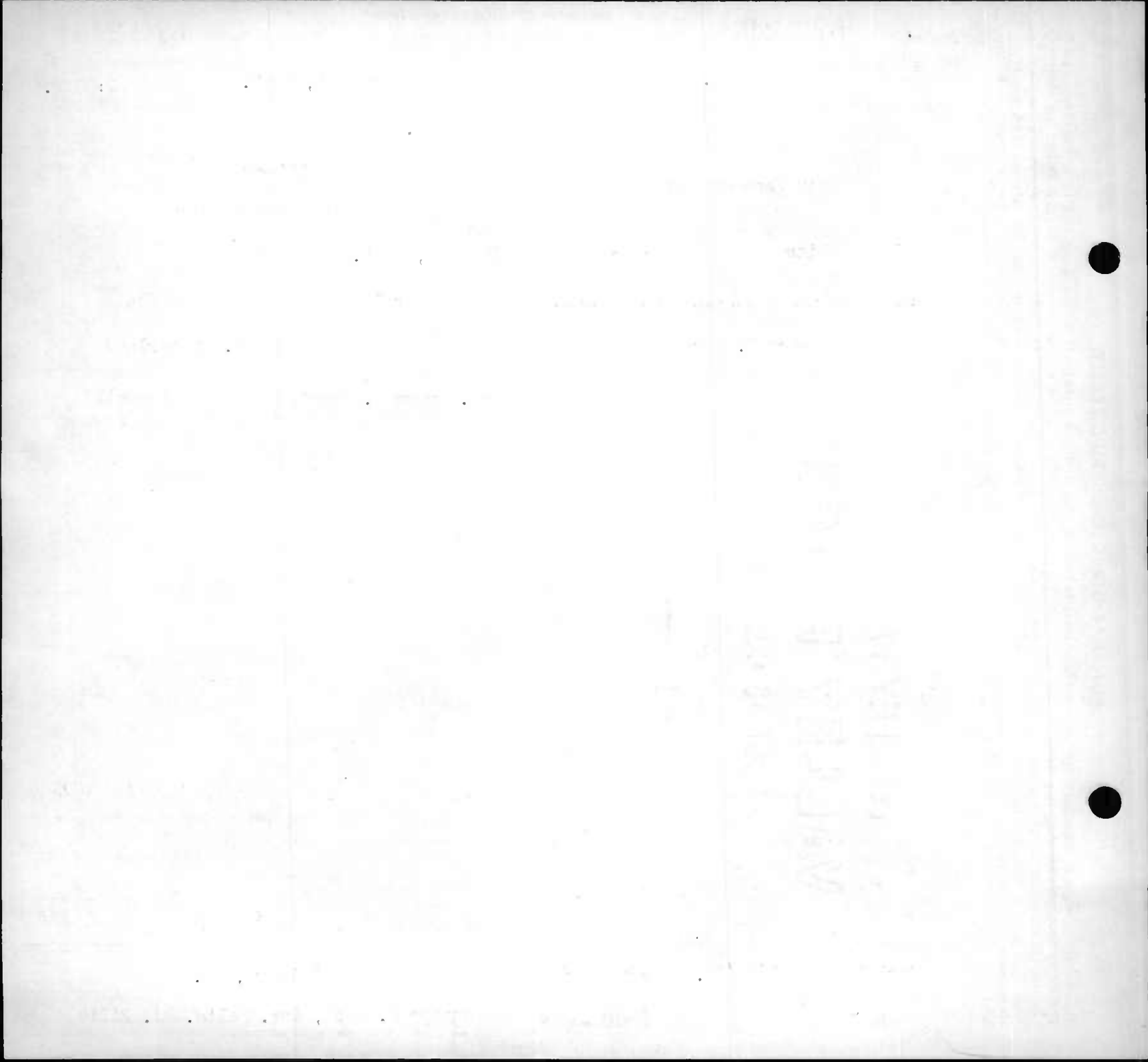
| BIRTH NO. 67 2463 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2463 | |
|---|-------------------------|---|--|---|--|--|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Olive R. Brenner</i> | | | | 2. DATE AND HOUR OF DEATH <i>March 12, 1967. 12:10 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Gould Convalesarium</i> | | | | A. STATE <i>Md.</i> B. COUNTY <i>27-0</i> | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 21214</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>2825 E. Northern Parkway</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>July 23, 1895</i> | 9. AGE (In years last birthday) <i>71</i> | 10. Under 1 Yr. Months: Days | | 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>Edward Hecker</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Effie Calimer</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>219-22-8286</i> | | 17. INFORMANT ADDRESS <i>Mr. Charles L. Brenner (Same)</i> | |
| 18. <i>15381</i> | | | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Metastatic Carcinoma of liver 5 weeks</i> <i>Primary carcinoma of colon 6 months</i> | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>asst Hypertensive Arteriosclerotic C. V. disease 20 yrs</i> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Jan 4</i> 19 <i>47</i> to <i>March 12</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>March 11</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>H. V. Harbold</i> M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>March 13, 1967</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>H. V. HARBOLD</i> M.D. | | | | 23D. ADDRESS <i>4706 Harford Road Baltimore, Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3/15/67</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Parkwood Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 13 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i> | | ADDRESS <i>Balto. Md. 21214</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|-------------------------|--|--|--|--|
| BIRTH NO. 67 2464 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2464 | |
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) EMMA E. EMMART | | | 2. DATE AND HOUR OF DEATH March 11, 1967. 2:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2810 Kennedy Avenue | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2810 Kennedy Avenue | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH June 30, 1885. | 9. AGE (In years last birthday) 91 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machine Operator Shoe Factory | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Henry D. Emmart | | |
| 14. MOTHER'S MAIDEN NAME Emma V. Cumberland | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 212-03-2756 | | | 17. INFORMANT Mrs. Irene J. Preston | | |
| 18. ADDRESS (Same) | | | 19. INTERVAL BETWEEN ONSET AND DEATH | | |
| 18. 420.01 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anterior Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Senility | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from March 10 1967 to March 11 1967 , that (I) last saw the deceased alive on March 10 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James F. White M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 3/13/67 | |
| 23C. PHYSICIAN'S NAME (Type) James F. White M.D. | | | | 23D. ADDRESS 5214 Harford Road, Balto 21214 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/14/67. | | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214 | |
| 25D. ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2465 | |
|---|---------------------|--|-------------------------------------|---|--|
| BIRTH NO. 67 2465 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>SCHMIDT, WILLIAM A DAM</i> | | 2. DATE AND HOUR OF DEATH <i>11 MARCH 67 2:00 P. M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>STEARNS</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 21213</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>44 UNION MEMORIAL HOSP</i> | | D. STREET ADDRESS (If rural, give location) <i>3320 ELMLEY AVE</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>67-06-99</i> | 9. AGE (In years last birthday) <i>67</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED Policeman</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>MD</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>ADAM SCHMIDT</i> | | 14. MOTHER'S MAIDEN NAME <i>MARTHA Landau</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Yes WW1</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mrs. Agnes R. Schmidt</i> | |
| 18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) DUE TO <i>Acute myocardial infarction</i> (B) DUE TO <i>Coronary arteriosclerosis with thrombosis of left coronary artery (ant. descending) left ventricle</i> (C) <i>M. Dipolito M.D.</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (A) (this hospital) attended the deceased from <i>18 FEB 1967</i> to <i>11 MARCH 1967</i> , that (B) (we) lost saw the deceased alive on <i>11 MARCH 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Sidney E. Kirkley</i> | | | | 23B. DATE SIGNED <i>11 March 67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>SIDNEY E. KIRKLEY</i> | | | | 23D. ADDRESS <i>THE UNION MEMORIAL HOSPITAL</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3/15/67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 13 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Feltman</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Buck, Inc. Balto. Md. 21214</i> | |

THE LONDON FIELD OFFICE

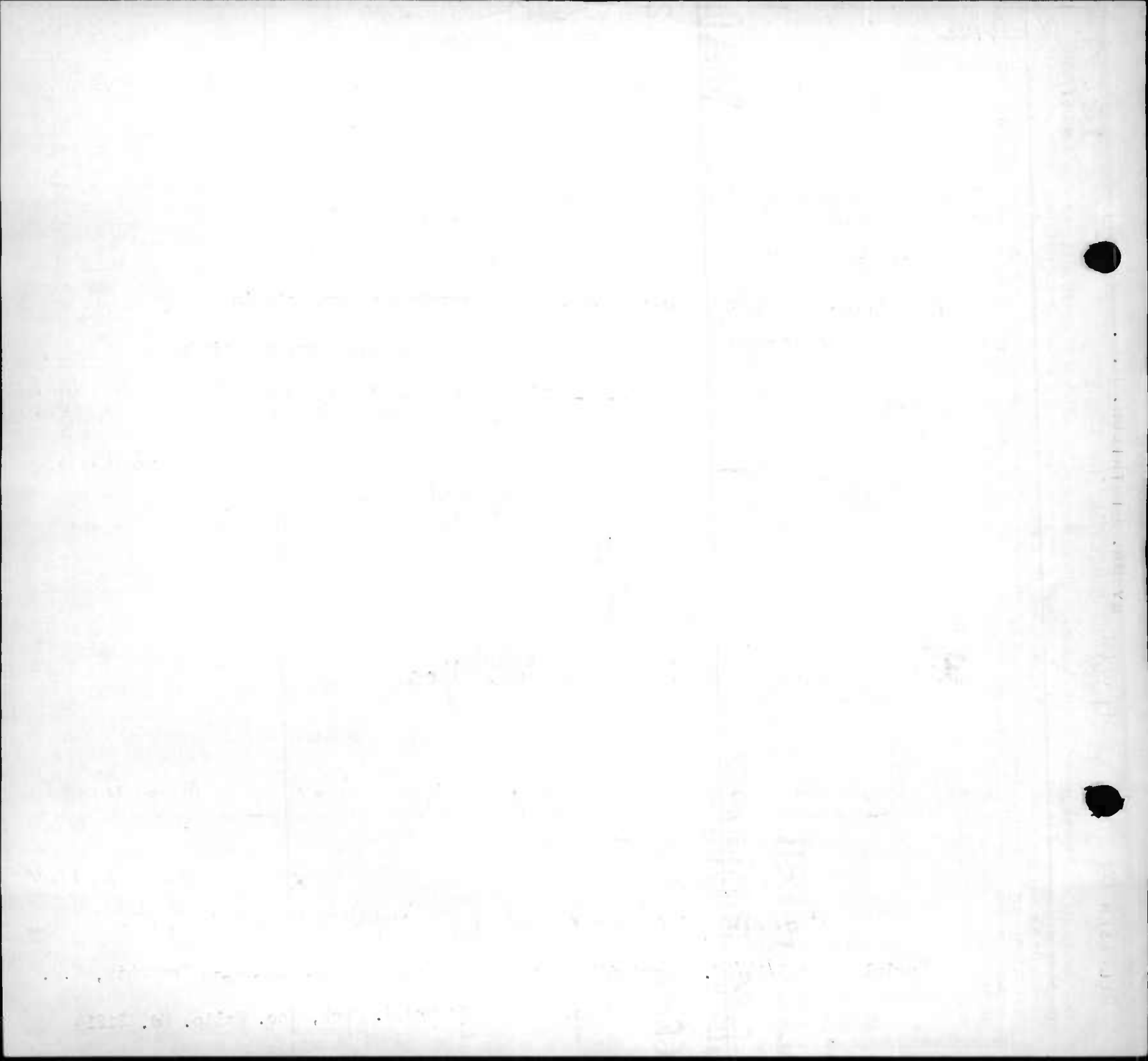
21/11/54

RE: [illegible]

[illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

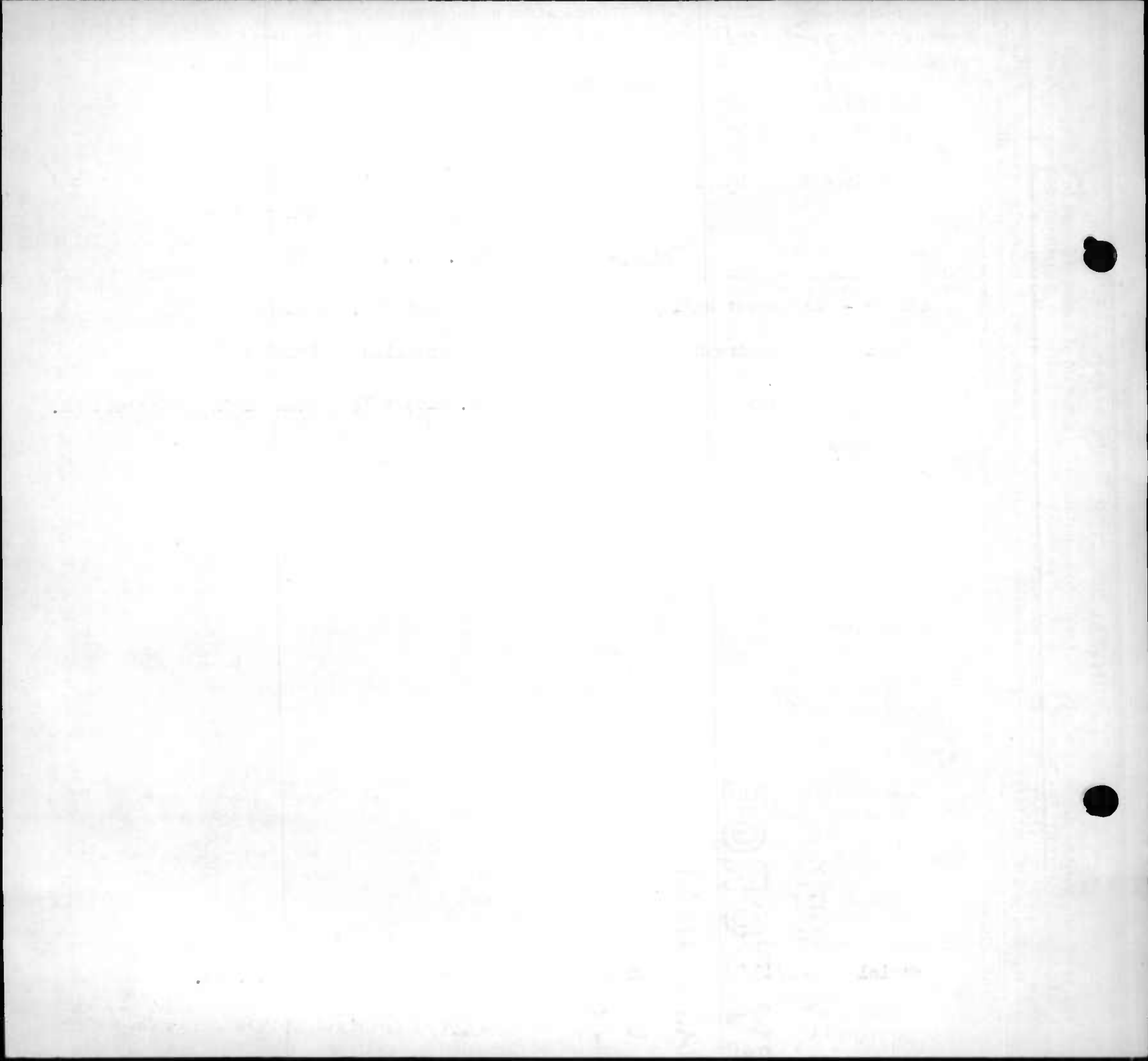
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|--|--|--|--|--|--|
| BIRTH NO. 67 2466 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2466 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | MARIPUU, OLGA | | 2. DATE AND HOUR OF DEATH MARCH 11, 1967 5:15 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital, 33 Baltimore, Maryland 21205 | | Maryland 21213 Baltimore | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | |
| 8. DATE OF BIRTH April 20, 1906 | | 9. AGE (In years last birthday) 60 yrs. | | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Venetian Blind Factory - Metal Worker | |
| 11. BIRTHPLACE (State or foreign country) Leston, Estonia | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME WIRRO, LEONARD | |
| 14. MOTHER'S MAIDEN NAME WIRRO, Linda | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-58-8836 | |
| 17. INFORMANT MARIPUU, LOIT, 3215 Ramsey Dr., Ann Arbor Michigan | | ADDRESS | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) D. Subarachnoid hemorrhage about 8 days from ruptured aneurysm of the vertebral artery. E. High Blood Pressure. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, given rise to the above cause (A) stating UNDERLYING CONDITION last. | | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. | | | | | |
| 21. DATE OF OPERATION 3/11/67 and 3/10/67 | | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED Vaginal Bleeding, Subarachnoid hemorrhage. | | 23. AUTOPSY? (Yes or No) Yes. | |
| 24. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 26. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 27. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 28. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 29. HOW DID INJURY OCCUR? | |
| 30. I certify that (I) (this hospital) attended the deceased from Feb 28, 1967 to March 11, 1967, that (I) last saw the deceased alive on March 11, 1967 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | | | |
| 31. SIGNATURE C. Bhushan | | 32. DATE SIGNED March 11, 1967 | | | |
| 33. PHYSICIAN'S NAME (Type) CHHABI BHUSHAN | | 34. ADDRESS The Johns Hopkins Hospital, Baltimore, Maryland 21205 | | | |
| 35. BURIAL CREMATION, REMOVAL (Specify) Burial | | 36. DATE 3/14/67 | | 37. NAME OF CEMETERY or CREMATORY Northville Lutheran Cemetery | |
| 38. LOCATION Upper Deerfield Township, N.J. | | 39. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 40. NAME OF REGISTRAR Leonard J. Ruck, Inc. Balto. Md. 21214 | |



FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---|------------------|---|---|--|--|---|------------------------------|--|----------------------------------|
| BIRTH NO. 67 2467 | | | | | REGISTERED NO. 67 2467 | | | | |
| M.E. CASE NO. | | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | |
| 1. NAME OF DECEASED (Type or Print) August Zimmerman | | | | | 2. DATE AND HOUR OF DEATH 3/10/67 1735 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3900 North Charles Street | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-01 D. STREET ADDRESS (If rural, give location) 3900 North Charles Street | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH Oct. 11, 1887 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Government | | | 10B. KIND OF BUSINESS OR INDUSTRY employee | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Charles Zimmerman | | | 14. MOTHER'S MAIDEN NAME Caroline Schmidt | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Mr. Albert Zimmerman | | | ADDRESS 1401 Cedarcroft Rd. | | | |
| 18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH (A) Generalized Cerebral DUE TO Anteromedian with multiple (B) Cerebrovascular accident DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1955 to Jan 9 1967, that (I) (we) last saw the deceased alive on Jan 9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Walter B. Buck | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/10/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) WALTER B. BUCK | | | | 23D. ADDRESS M.D. 18 E. EAGER BALTIMORE MD | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/13/1967 | | 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery | | 24D. LOCATION (City, town, or county) (State) Pikesville, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Wm. J. Zerkow & Son ADDRESS Multon Ind. North Pa. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2466 | |
|--|--------------|---|----------------------------|--|--------------------------------------|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 67-05184 67 2466 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) John Joseph Nazarenus Jr. | | 2. DATE AND HOUR OF DEATH 7:40 3-10-67 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 36 FRANKLIN SQUARE HOSPITAL 110 N. CALHOUN ST. BALTO. 23-Md. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Bkts. 20-05 | | | |
| | | D. STREET ADDRESS (If rural, give location) 2301 Frederick Avenue | | | |
| 5. SEX m | 6. RACE w | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 3-9-67 | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days 1 1 1 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) BALTO. Md. | |
| 13. FATHER'S NAME JOHN JOSEPH NAZARENUS SR | | 14. MOTHER'S MAIDEN NAME Clarissa Mayo | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT CHART ADDRESS | |
| 18. 761.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Prolonged anoxia in utero. (B) DUE TO abruptio placenta 29 hrs. (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/9/1967 to Mar 10 1967, that (I) (we) last saw the deceased alive on Mar 11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Coral Gordon | | | | 23B. DATE SIGNED 3/11/67 | |
| 23C. PHYSICIAN'S NAME (Type) CORAL GORDON | | 23D. ADDRESS 611 Park Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/11/67 | | 24C. NAME OF CEMETERY or CREMATORY Landon Park | |
| 24D. LOCATION (City, town, or county) (State) Bkts. Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 13 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Phyllis Cohen - Son Inc 901 Hollins St. Bkts. Md. | | | |

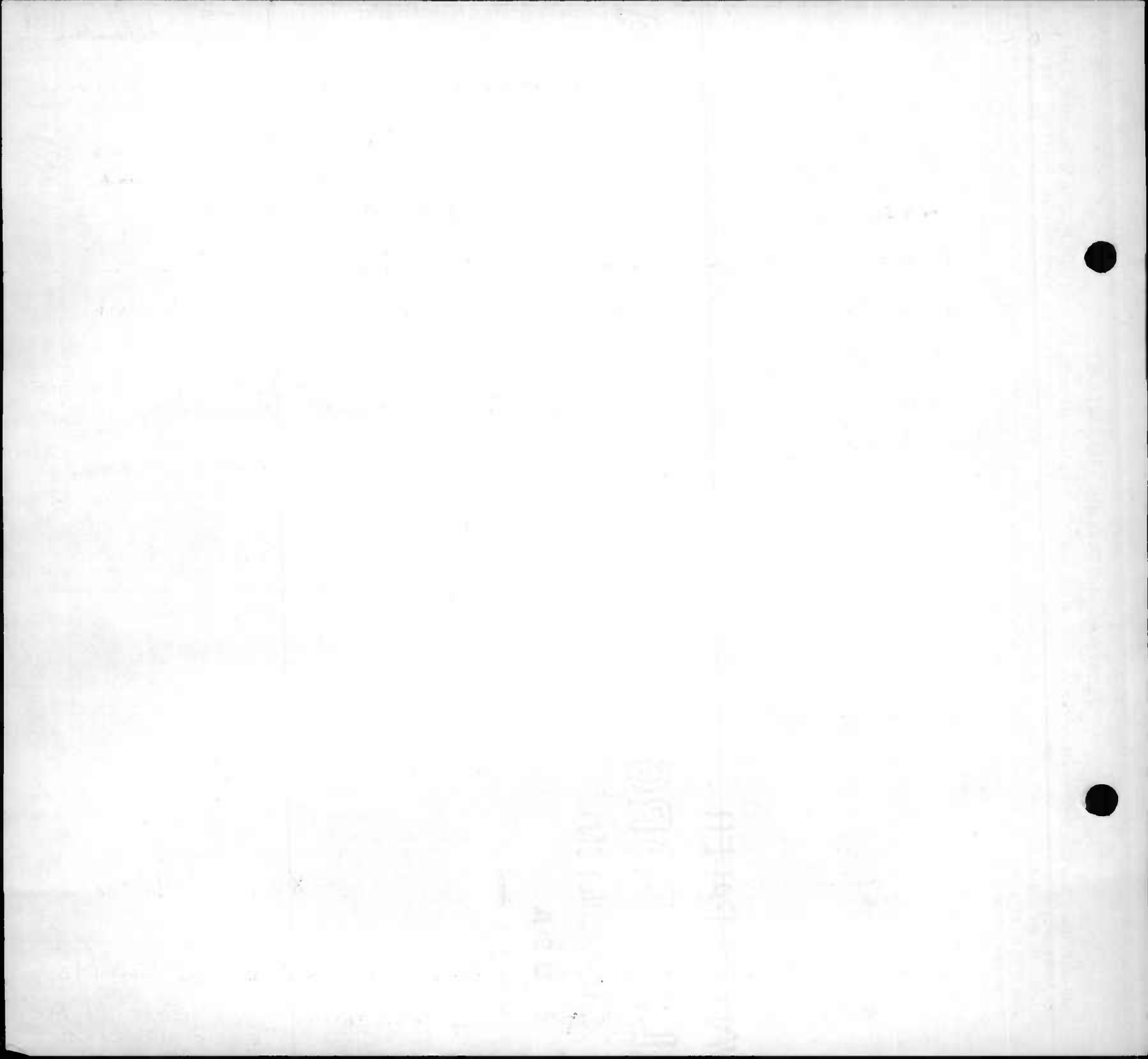
111 York Ave

Good Luck

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2469 | |
|---|------------------|--|---|---|--|
| BIRTH NO. 67 2469 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | John Olecki-ULEKSKI-ALEX | | 3/11/67 3/11/67 11:14 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL 37 | | | A. STATE MARYLAND 21225 | | |
| If not in hospital or institution, give street address or location | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 25-05 | | |
| | | | D. STREET ADDRESS (If rural, give location) 1315 PATAPSCO AVE. | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 6-11-89 | 9. AGE (In years last birthday) 77 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER | | 10B. KIND OF BUSINESS OR INDUSTRY MD. DRYDOCK | 11. BIRTHPLACE (State or foreign country) POLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME UNKNOWN | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 217-05-6419 | 17. INFORMANT JULIA OLECKI | | ADDRESS 1315 PATAPSCO AVE. BALTO. MD. 21225 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION 609X I | | | CAUSE OF DEATH (A) DUE TO Bacterial Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH 3 days |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO Urinary tract infection | | 21 days |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Atherosclerotic cardiovascular disease, Anemia, Bone marrow depression 20 to 40, Chlormphenical, Chronic brain syndrome | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 2/14 1967 to 3/11 1967, that (1) (we) last saw the deceased alive on 3/11 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Louie E. Gunzer | | | | 23B. DATE SIGNED 3/11/67 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-14-67 | 24C. NAME of CEMETERY or CREMATORY HOLY CROSS CEM. | | 24D. LOCATION (City, town, or county) (State) ANNE ARUNDEL Co., MD. |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967 | | 25B. NAME OF REGISTRAR L. E. Gunzer | | 25C. FUNERAL DIRECTOR UD FALKOWSKI | |
| | | | | ADDRESS 2007 EASTERN AVE. BALTO. MD. 21231 | |



N 86-615670002478

R. V. G. J.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|--|--|--|---|--|
| BIRTH NO. 67 2471 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2471 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>JUBB THEODORE</i> | | 2. DATE AND HOUR OF DEATH <i>3-10-67 8⁵⁰ P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED HOSPITAL OR INSTITUTION <i>South Baltimore Gen. Hospital 43</i> 3-23-67 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>Anne Arundel</i> | | | |
| 5. SEX <i>m.</i> 6. RACE <i>w.</i> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | | 8. DATE OF BIRTH <i>March 19, 1916</i> | | 9. AGE (In years, months, days, hours, minutes) <i>51 yrs. 56 yrs.</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bartender (ret.)</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Tavern</i> | | 11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Joshua C. Jubb (decd.)</i> | | 14. MOTHER'S MAIDEN NAME <i>Grace Jones (liv.)</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>220 03 0580</i> | | 17. INFORMANT <i>Mrs. Florence E. Jubb (wife)</i> | |
| 18. I <i>143X I</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Cancer of Floor of the Mouth</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i></i> | | | |
| (C) <i></i> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <i>Cirrhosis of the Liver. -</i> | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i></i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>2-16 1967</i> to <i>2-10 1967</i> , that (I) (we) last saw the deceased alive on <i>3-10 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Joseph V. Iglesias</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>3-10-67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Jose V. Iglesias</i> | | 23D. ADDRESS M.D. <i>South Baltimore General Hosp.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>March 14/67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Brooklyn, RFD, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 14 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i> | |
| 25C. FUNERAL DIRECTOR <i>Singleton Funeral Home</i> | | 25D. ADDRESS <i>Glen Burnie, Md.</i> | | | |

[Handwritten signature]

1
67 2472
BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2472

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) JULIA UREVITCH 2. DATE AND HOUR PRONOUNCED DEAD 3-8-67 11:05 AM.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-02
D. STREET ADDRESS (If rural, give location) 603 Cathedral Street - Apt. 3-D

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 603 CATHEDRAL STREET - Amb. Crew #7

5. SEX Female 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married 8. DATE OF BIRTH 5/21/08 9. AGE (In years last birthday) 58 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown 10B. KIND OF BUSINESS OR INDUSTRY Unknown 11. BIRTHPLACE (State or foreign country) Pa. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Stanley Urevitch 14. MOTHER'S MAIDEN NAME Eva Lucien

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 027-05-5970 17. INFORMANT Bernard F. Jure 604 Wooddale Rd. - Linthicum, Md.

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Bilateral bronchopneumonia
DUE TO
(A) (B) (C)
INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
Astrocytoma of brain
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) Yes 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner
CHIEF MEDICAL EXAMINER
ACTUAL SIGNATURE EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D. DATE SIGNED 3-8-67

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 3/11/67 23C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery 23D. LOCATION (City, town, or county) (State) Brooklyn, Maryland

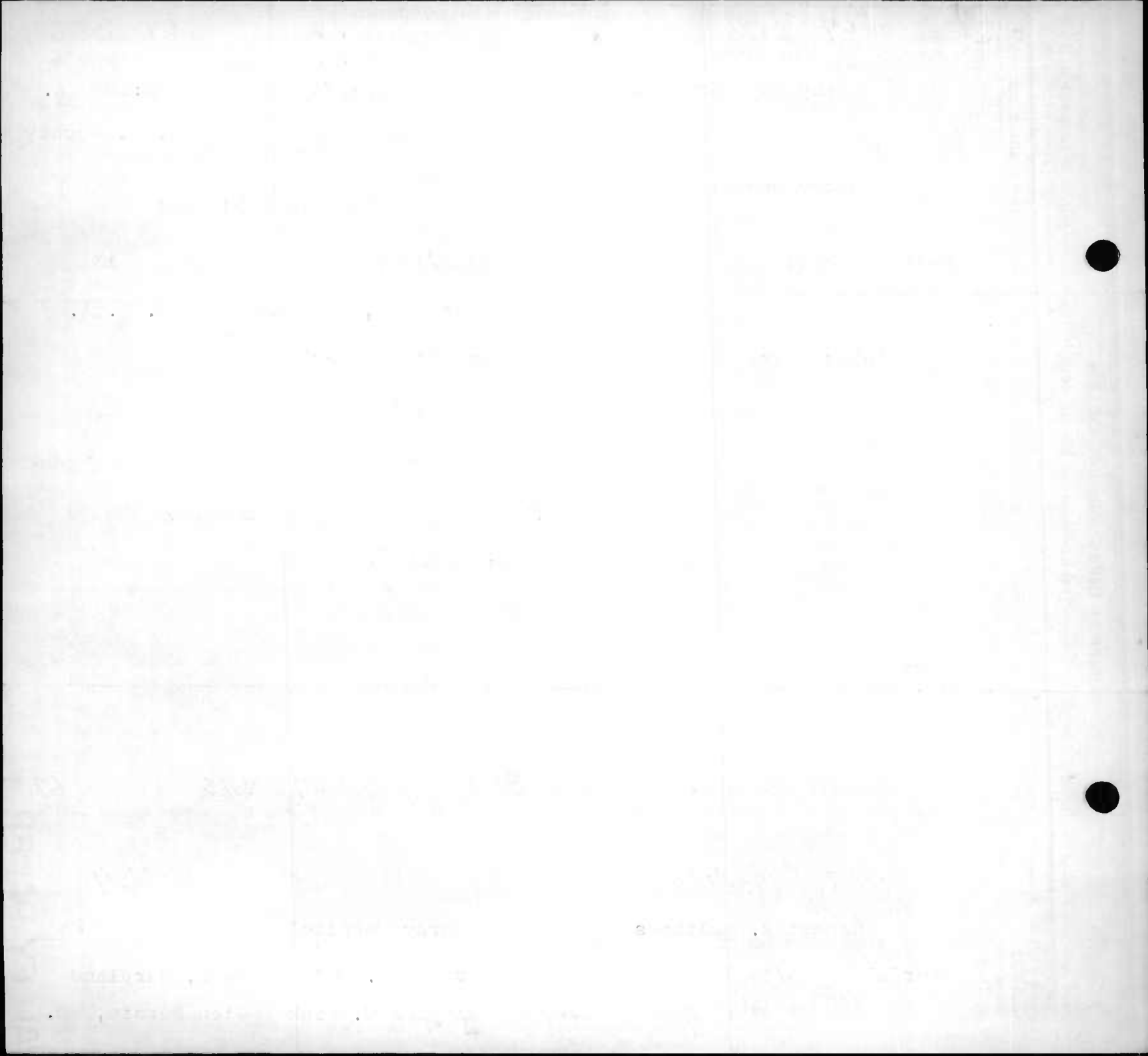
24A. DATE REC'D MAR 14 1967 24B. NAME OF REGISTRAR Robert E. Fairman 24C. FUNERAL DIRECTOR Singleton Funeral Home/Glen Burnie, Md. ADDRESS

WALLACE BOWEN

FUNERAL DIRECTOR: IMPORTANT

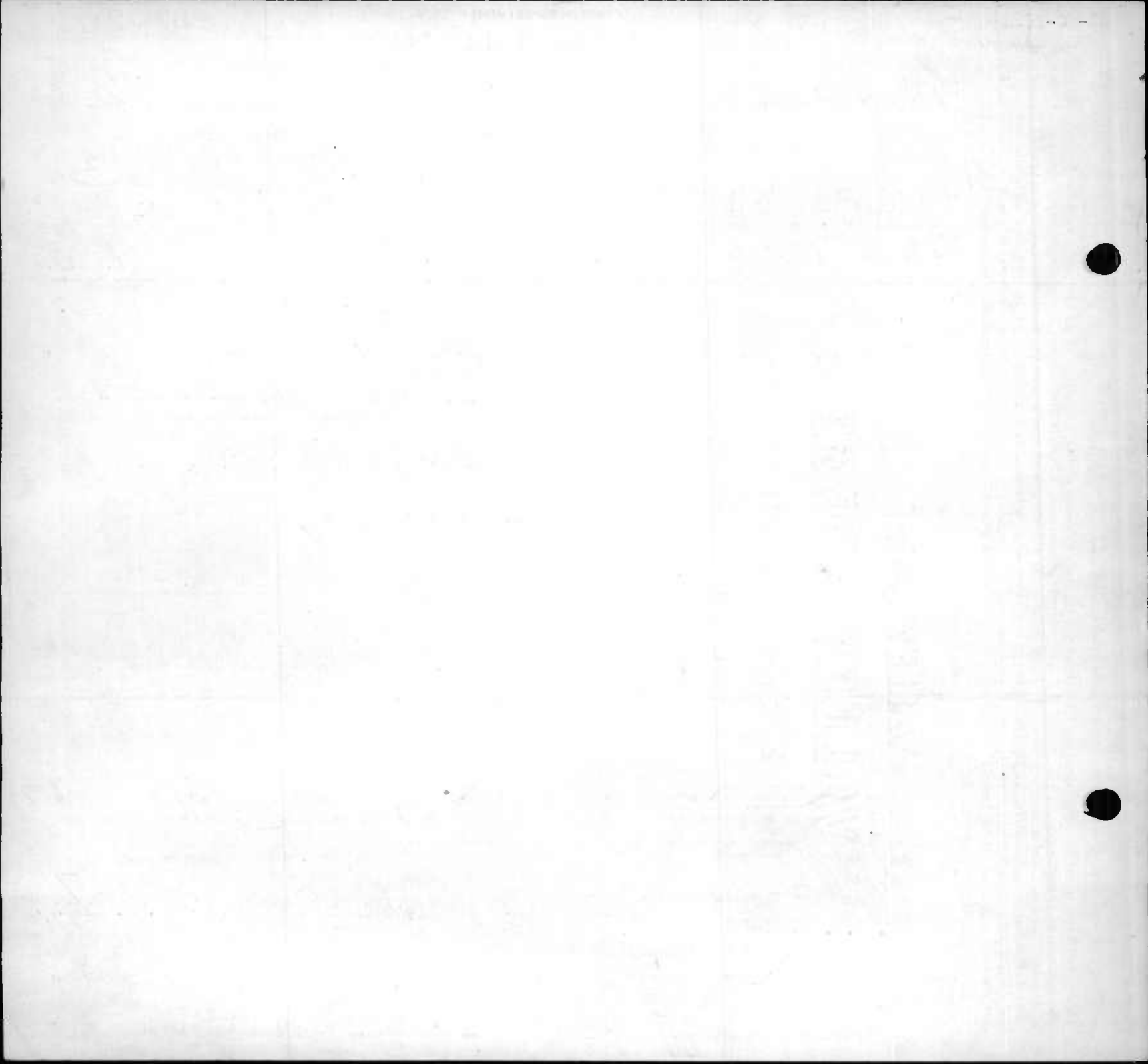
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2473 | |
|--|-------------------------|--|--------------------------------------|--|--|
| BIRTH NO. 67-06257 2473 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 3/13/1967 3:23 a. m. | | | |
| 1. NAME OF DECEASED (Type or Print) Baby Boy Warfsman | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY A. A. County | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 Mercy Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Glen Burnie 52-00 D. STREET ADDRESS (If rural, give location) 458 Old Quarterfield Road | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 3/12/1967 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 13 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Richard Warfsman | | | |
| 14. MOTHER'S MAIDEN NAME Angela (Eutsler) | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital Records | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshteno, etc. It means the disease, injury or complication which caused death.) 762.5 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Anoxia DUE TO (B) Respiratory distress syndrome DUE TO (C) Prematurity | | INTERVAL BETWEEN ONSET AND DEATH 13 hrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/12 19 67 to 3/13 19 67 , that (I) (we) last saw the deceased alive on 3/13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert R. Holthaus | | | | 23B. DATE SIGNED 3/13/67 | |
| 23C. PHYSICIAN'S NAME (Type) Robert R. Holthaus | | | | 23D. ADDRESS Mercy Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/14/1967 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Ph. Glen Burnie, Maryland | |
| 24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967 | | 25B. NAME OF REGISTRAR Robert E. Fink | |
| 25C. FUNERAL DIRECTOR Raymond C. Fink | | ADDRESS Glen Burnie, Md. | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--|---------|--|------------------|--|-----------------------------|
| B-122 67 2474 67-04255 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2474 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED | |
| MARTHA BUBCZUK | | BABY GIRL "B" | | 2. DATE AND HOUR OF DEATH | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | |
| Baltimore City Hospital 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | Maryland Baltimore | | 2-03 1922 Fleet St 21231 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| FEMALE | WHITE | NEVER MARRIED | 3/3/67 | 0 | 15 00 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Baby | | | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Ronald Bubczuk | | Martha | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | BCH: RECORDS 4940 EASTERN AVENUE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) Respiratory distress syndrome | | 15 hrs | |
| ANTECEDENT CAUSES | | (B) Immaturity | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/3 1967 to 3/3 1967. | | that (I) (we) lost saw the deceased alive on 3/3 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Dr. A.M. Overbach | | 3/3/67 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| DR. A.M. OVERBACH | | 4940 EASTERN AVENUE BALTO. MD. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Cremation | | 3-8-67 | | Baltimore City Hospitals Baltimore, Maryland 21224 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 14 1967 | | J. E. Taylor | | HOSPITAL DISPOSAL | |



FUNERAL DIRECTOR: IMPORTANT

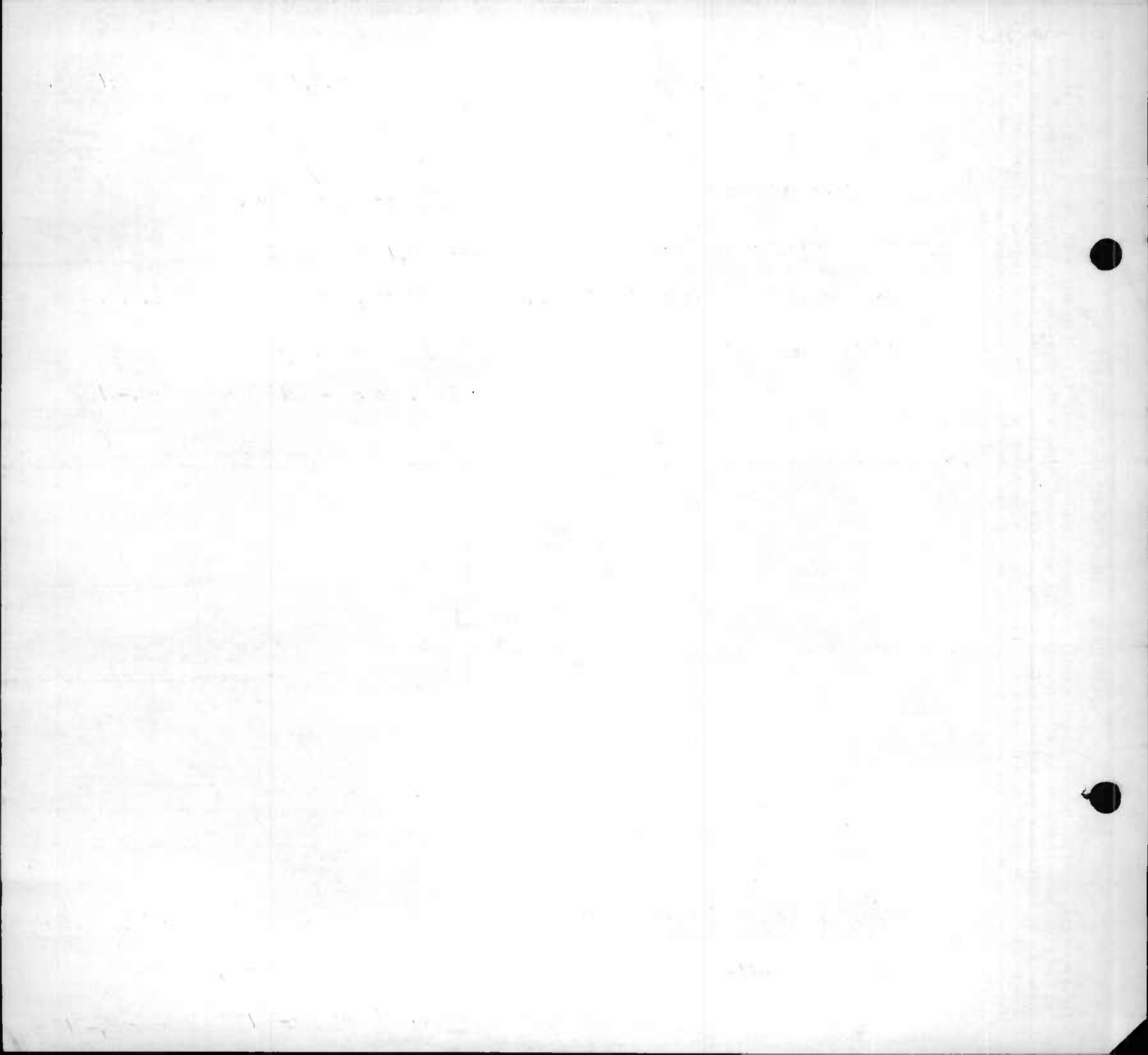
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 67 2475 | |
|--|---|--|---|---|--|---|-----------------------|
| BIRTH NO. 67 2475 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JULIA E. Mc NANEY | | 2. DATE AND HOUR OF DEATH 3-9-67 7:25 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15-10 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 4012 Main Ave., #21207 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 12-17-83 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY HOUSE WORK | | 11. BIRTHPLACE (State or foreign country) NEBRASKA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME PAUL G. SCHULTE | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 218-09-9689A | | 17. INFORMANT GEORGE E. GESSLER | | ADDRESS 303 S. BAYLIS ST. BALTO. 21224, MD. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, esthenia, etc. It means the disease, injury or complication which caused death.) C.V.A. Hypertension | | | | CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH | | | |
| 18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-9-67 19 67 to 3-9 19 67 , that (I) (we) last saw the deceased alive on 3-9-67 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Lucas C. Vidhyaphum M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3-9-67 | |
| 23C. PHYSICIAN'S NAME (Type) LUCAS C. VIDHYAPHUM M.D. | | | | 23D. ADDRESS Lutheran Hospital of Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-13-67 | | 24C. NAME OF CEMETERY or CREMATORY BALTIMORE CEMETERY | | 24D. LOCATION (City, town, or county) (State) E. NORTH AVE. BALTO., MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967 | | 25B. NAME OF REGISTRAR Robert E. Hall | | 25C. FUNERAL DIRECTOR Charles S. Zeller | | ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--|-------------------------|---|---|---|---|--|---|--|---------|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2476 | | | | |
| BIRTH NO. 67 2476 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Margueritte M. Ward</i> | | | | | 2. DATE AND HOUR OF DEATH <i>Mar. 7, 1967</i> <i>7:15 A. M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) 90 Hillcrest Nursing Home | | | | | A. STATE <i>Maryland</i> | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>5632 Loch Raven Blvd.</i> | | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>April 22, 1894</i> | 9. AGE (In years last birthday) <i>72</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Book keeper</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Schenuit Tire Co.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>William Ward</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Mary T. Coffay</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Marie V. Roach - 6242 Burgess Ave. - 21206</i> | | | ADDRESS | |
| 18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Generalized Carcinomatosis</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i> | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO | | | | |
| | | | | | (B) DUE TO <i>Carcinoma uterus</i> | | | | |
| | | | | | (C) DUE TO | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Christian J. Richter</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS <i>1001 St. Paul St. - Balt. 2, Md.</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3-11-67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral Cemetery</i> | | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR <i>John G. Miller</i> | | | 25C. FUNERAL DIRECTOR <i>John G. Miller Inc - 6415 Belair Road, - 21206</i> | | | ADDRESS |



L-552

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 2477 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 67 2477

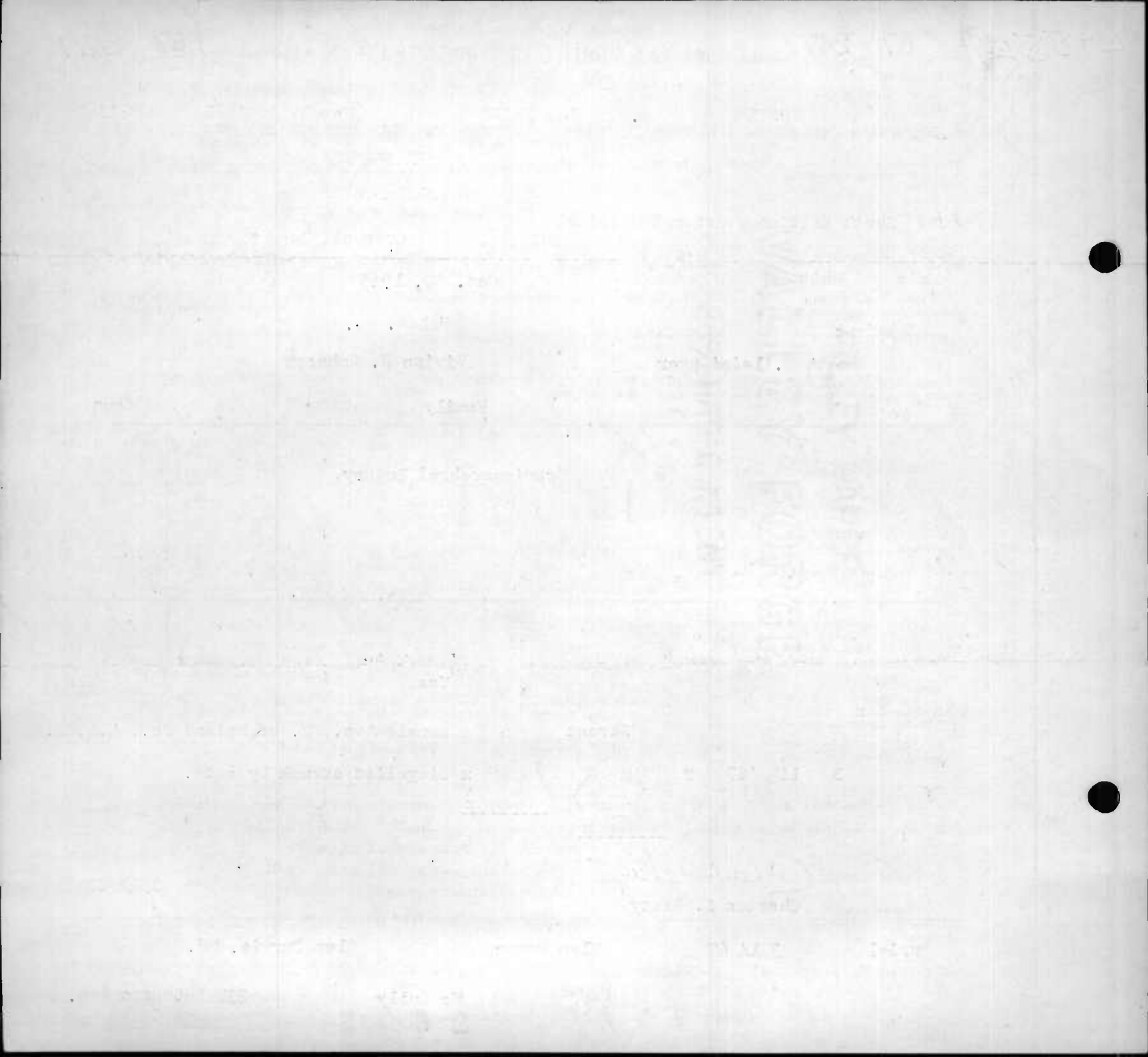
M.E. CASE NO.

| | | | | | |
|--|-------------------------|---|--|--|---|
| 1. NAME OF DECEASED (Type or Print) JUSTIN C. LEININGER | | | 2. DATE AND HOUR PRONOUNCED DEAD March 11, 1967 3:15 P | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-4-6 C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 227 Creswell Road | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH Oct. 30, 1955 | 9. AGE (In years last birthday) 11 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10B. KIND OF BUSINESS OR INDUSTRY School | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | 13. FATHER'S NAME Scott D. Leini nger | | |
| 14. MOTHER'S MAIDEN NAME Vivian J. Johnson | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown), (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family | | ADDRESS Same | |

| | | | | | |
|---|--|---|--|--|--|
| 18. 813.4 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Craniocerebral Injury. DUE TO (B) DUE TO (C) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Bonair Ave., E. of Upland Dr., A.A.Co. | | | |
| 21D. TIME OF INJURY (APPROX.) 3 11 '67 P | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Bicyclist struck by auto. | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 3/12/67 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 3 14 67 | | 23C. NAME of CEMETERY or CREMATORY Glen Haven | |
| 23D. LOCATION (City, town, or county) (State) Glen Burnie, Md. | | 24A. DATE REC'D BY HEALTH DEPT. | | | |
| 24B. NAME OF REGISTRAR Robert E. Farkas | | 24C. FUNERAL DIRECTOR Mc Gully | | ADDRESS 237 Patapsco Ave. | |

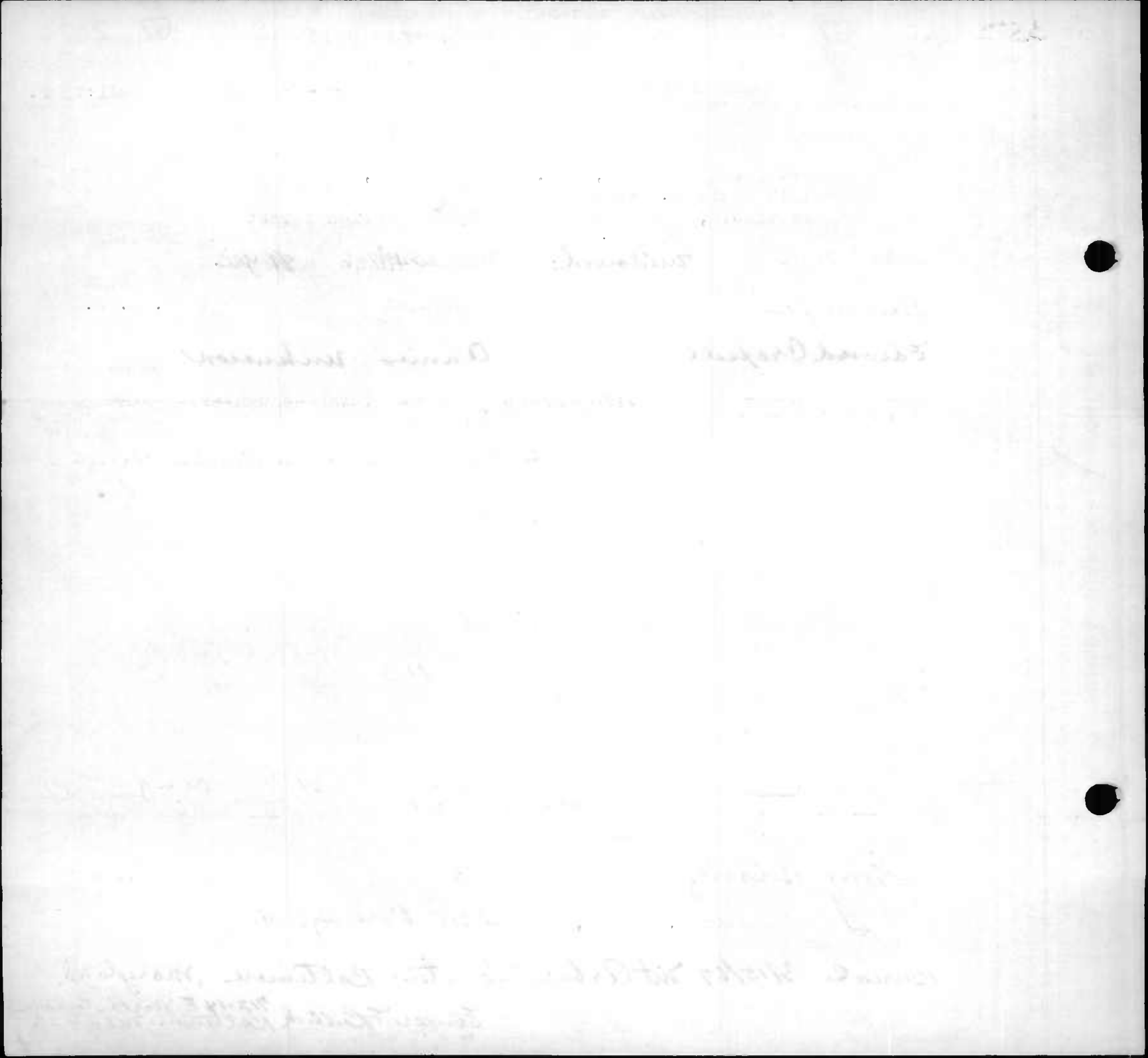
MAR 14 1967

2485



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---|-------------------------|---|--|--|---|
| BIRTH NO. 67 2478 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2478 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) Emma Giddings | | | 2. DATE AND HOUR OF DEATH 3-9-67 EOR 11:15 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, 17-02 D. STREET ADDRESS (If rural, give location) 1344 Division Street | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH March 4, 1886 | 9. AGE (In years last birthday) 81 yrs | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Edward Chopell | | | 14. MOTHER'S MAIDEN NAME Annie unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. 217-03446A | 17. INFORMANT Delores (grand-daughter) | | ADDRESS SAME |
| 18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular System. INTERVAL BETWEEN ONSET AND DEATH Acute Onset | | | | | |
| II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ANTECEDENT CAUSES | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) this hospital attended the deceased from Mar 9 1967 to Mar 9 1967 that (I) we last saw the deceased alive on Mar 9 1967 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) we did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Simon H. Carter | | | | 23B. DATE SIGNED 10 Mar 67 | |
| 23C. PHYSICIAN'S NAME (Type) Simon H. Carter | | 23D. ADDRESS 4245 Park Heights Dr. | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/15/67 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967 | | | |
| 25B. NAME OF REGISTRAR P. B. E. Fickman | | 25C. FUNERAL DIRECTOR Edna E. Bullock | | | |
| ADDRESS 712-14 E. North Avenue | | Baltimore, Maryland | | | |



1
M-610

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 67 2479
66-2081
M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2479

| | | | |
|---|---|--|---|
| 1. NAME OF DECEASED (Type or Print) ANDREW MURPHY | | 2. DATE AND HOUR PRONOUNCED DEAD March 11, 1967 11:10 A. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED (If not in hospital or institution, give street address or location) 4-20-67 48 Maryland General Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 12-05 D. STREET ADDRESS (If rural, give location) 1711 Barclay Street | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Infant | 8. DATE OF BIRTH Sept. 24, 1966 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 5 If Under 1 Yr. If Under 24 Mos. Months Days Hours Min. |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Herman Hubbard | | 14. MOTHER'S MAIDEN NAME Bernice Murphy | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. Infant | 17. INFORMANT Mrs Bernice Murphy ADDRESS 1711 Barclay Street Baltimore Md. |
| 18. 492X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Giant Cell (probably viral) Pneumonitis Interstitial Pneumonitis---(SDII)--- | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/12/67 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | 23B. DATE 3/14/67 | 23C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | 23D. LOCATION (City, town, or county) (State) Baltimore Maryland |
| 24A. DATE REC'D BY HEALTH DEPT. MAR 14 1967 | 24B. NAME OF REGISTRAR Robert E. Farber | 24C. FUNERAL DIRECTOR Charles E. Ballou ADDRESS 712-14 E. North Ave Baltimore, Md 21202 | |

WALLACE FORGE

Released per Medical Exam. Office
N.K.B. 650
FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2480 | |
|--|--|---|--|--|--|
| BIRTH NO. 67 2480 | | | | 67 2480 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Anna Brown | |
| 2. DATE AND HOUR OF DEATH 6 Mar 67 | | | | 8:40 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospito) or institution, give street address or location) University Hospital 38 | | | | A. STATE B. COUNTY No Baltimore 402 | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | D. STREET ADDRESS (If rural, give location) 102 N. Paca Street | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | |
| 8. DATE OF BIRTH 1-11-75 | | 9. AGE (In years last birthday) 92 yrs. | | 10. CITIZEN OF WHAT COUNTRY? USA | |
| 11. BIRTHPLACE (State or foreign country) New Jersey | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Belford Ayars | |
| 14. MOTHER'S MAIDEN NAME Sarah Carney | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. not known | |
| 17. INFORMANT Mrs. Bradshaw, Century Nursing Home | | ADDRESS 102 N. Paca | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 20. CAUSE OF DEATH Hypovolemic shock | | INTERVAL BETWEEN ONSET AND DEATH 2 or more hours | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | 22. GASTROINTESTINAL BLEEDING | | 2 or more days | |
| 23. undetermined | | 24. Fracture of hip | | EIS | |
| 25. 19A. DATE OF OPERATION 1966 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fractured hip, right | | 20A. AUTOPSY? (Yes or No) no. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8:20 PM 6 Mar 1967 to 8:40 PM 6 Mar 1967, that (I) (we) last saw the deceased alive on 8:40 PM 6 Mar 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sidney L. Stapleton, Jr. | | | | 23B. DATE SIGNED 6 Mar 1967 | |
| 23C. PHYSICIAN'S NAME (Type) Sidney L. Stapleton, Jr. | | | | 23D. ADDRESS University Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/10/67 | | 24C. NAME OF CEMETERY OR CREMATORY Bethel Cemetery | |
| 24D. LOCATION Bethel, Cecil Co. Md. | | 24E. DATE REC'D BY HEALTH DEPT. MAR 14 1967 | | 24F. NAME OF REGISTRAR Robert E. Hicks | |
| 24G. DATE REC'D BY HEALTH DEPT. MAR 14 1967 | | 24H. NAME OF REGISTRAR Robert E. Hicks | | 24I. FUNERAL DIRECTOR Hicks Home for Funerals, Elkton, Md. | |

10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2481 | |
|---|-------------------------|--|--|--|---|
| BIRTH NO. 67 2481 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) William J. Parks, Sr | | 2. DATE AND HOUR OF DEATH March 11, 1967 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 4155 Eierman Ave. | | A. STATE Maryland B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 4155 Eierman Ave. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Apr. 13, 1904 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME William J. Parks | | | |
| 14. MOTHER'S MAIDEN NAME ? Nestor | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS John O. Parks, 6019 Chinquapin Pkwy. | | | |
| 18. 420.11 | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO Hypertensive heart disease | | INTERVAL BETWEEN ONSET AND DEATH 2 years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO arteriosclerotic heart disease | | 2 years | |
| | | (C) DUE TO myocardial infarction | | 12 hours | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1964-9-19 to 3/11/67 , that (I) (we) lost saw the deceased alive on 2/27/67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sol Smith | | M.O. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/13/67 | |
| 23C. PHYSICIAN'S NAME (Type) Sol Smith | | 23D. ADDRESS 1261 E. Belvedere Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3/14/67 | | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967 | | | |
| 25B. NAME OF REGISTRAR R. O. E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Ulrich Funeral Home 4210 Belair Road. | | | |

10073410 NIKAIKOTO, M. and KAWANO, M. 1999, *Journal of Chemical Ecology*, **25**, 1039-1050.

1

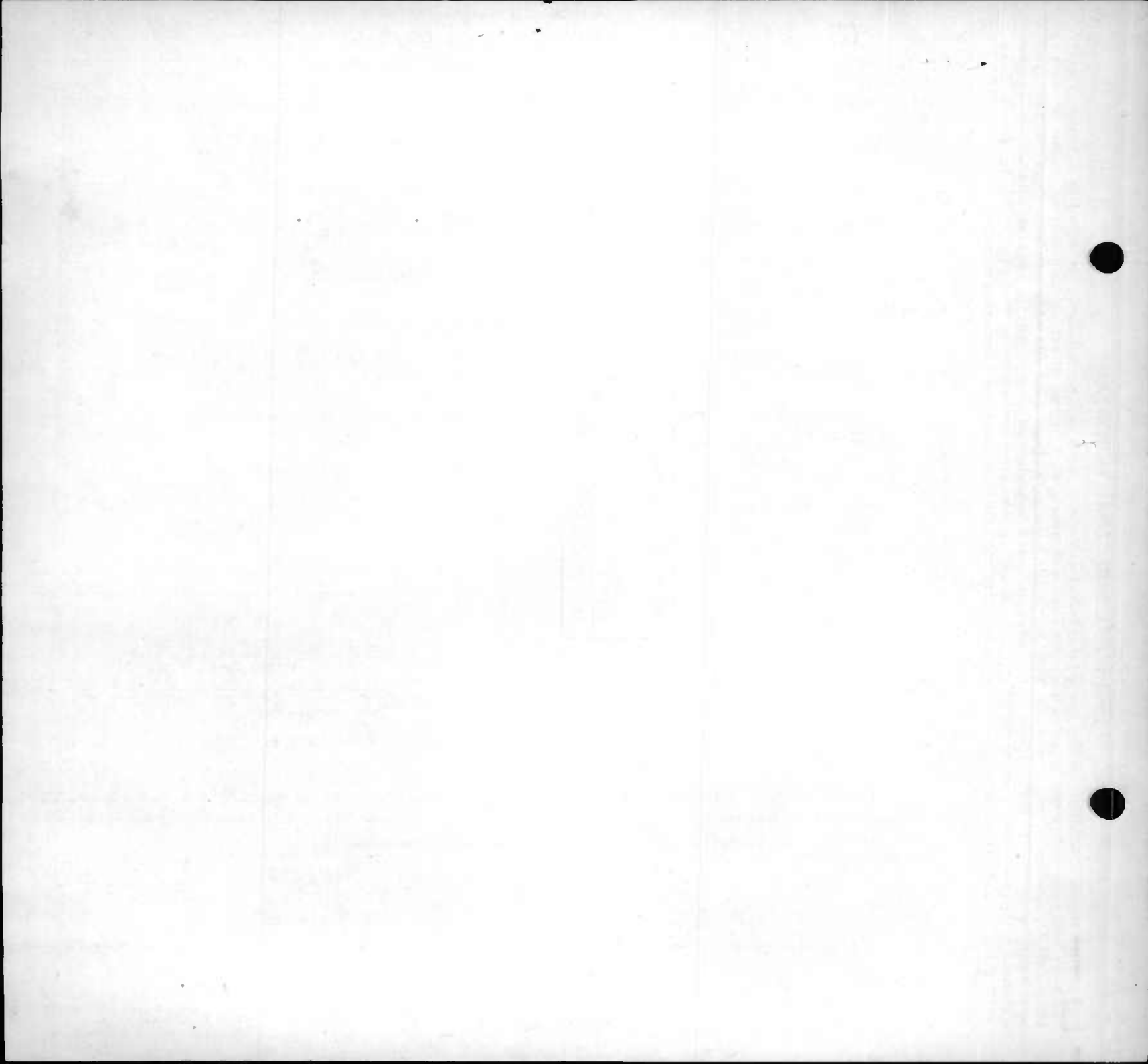


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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

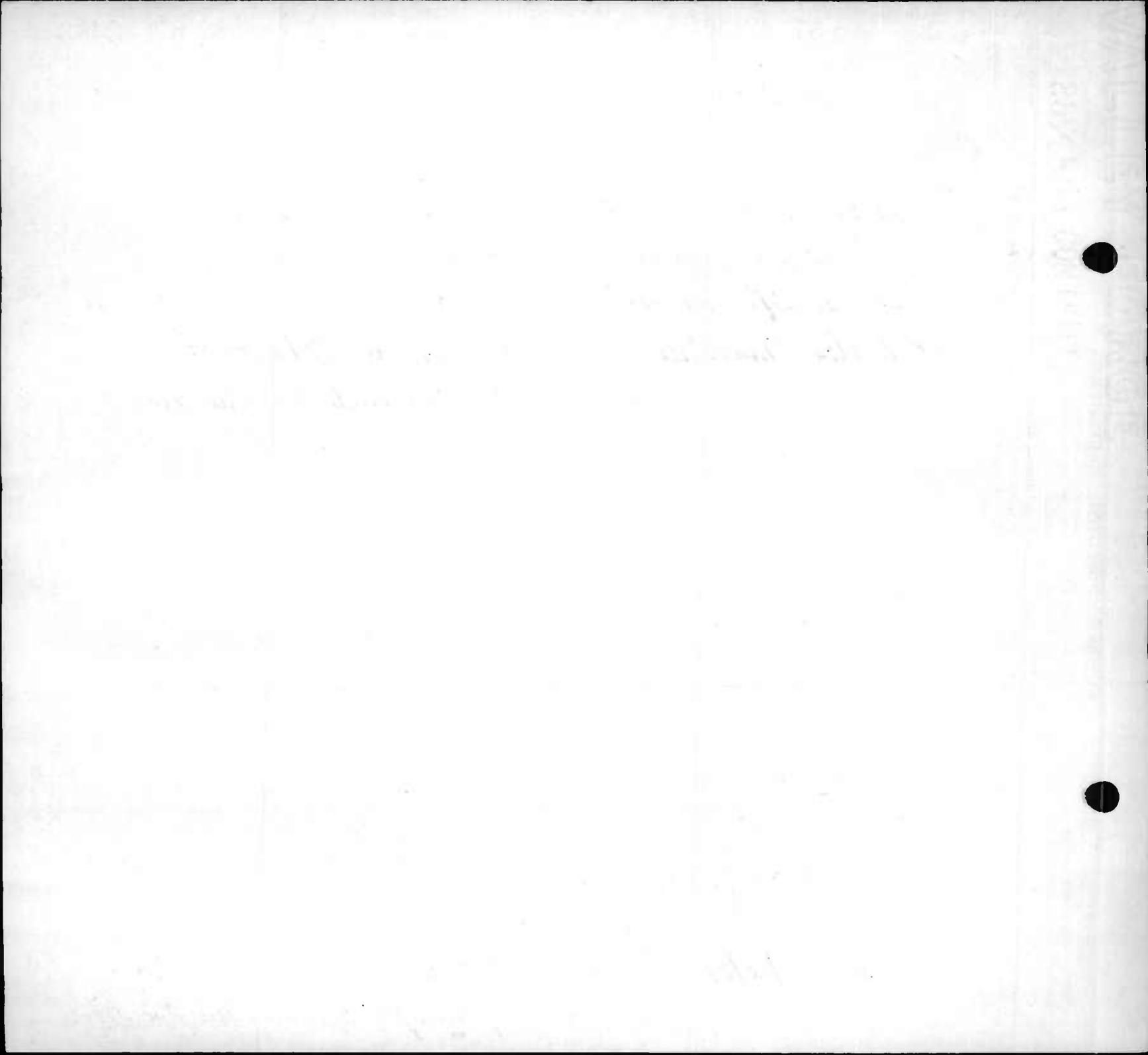
| | | | | | |
|--|--------------|--|-----------------------------|---|--|
| BIRTH NO. 67 2482 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2482 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) OLGA EMMA BYRON | | 2. DATE AND HOUR OF DEATH 3/13/67 11 15 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY 122 W Ostead ST | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 23-01 | | | |
| D. STREET ADDRESS (If rural, give location) 122 W. Ostead St. | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 11/7/02 | 9. AGE (In years last birthday) 64 | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERIC | | 10B. KIND OF BUSINESS OR INDUSTRY Red Drug + Chem Co | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME Frederick C. Johnson | | 14. MOTHER'S MAIDEN NAME HILDA Peterson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hepatitis | | 19. CAUSE OF DEATH Homologous serum | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, given rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | 20. ACUTE RENAL FAILURE | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2/1 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 00-00 | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/11/67 19 to 3/13/67 19, that (I) (we) last saw the deceased alive on 3/13/67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Sandra Z. Salan | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 3/11/67 | |
| 23C. PHYSICIAN'S NAME (Type) Sandra Z. Salan | | 23D. ADDRESS University Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3 16 67 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore | |
| 24D. LOCATION Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967 | | 25B. NAME OF REGISTRAR Robert E. Talley | | 25C. FUNERAL DIRECTOR McGully | |
| | | | | ADDRESS 130 E. Fort Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 67 2483 | |
|--|----------------------|--|--|---|--|--|--|
| BIRTH NO. 67 2483 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Florence Laurens</i> | | 2. DATE AND HOUR OF DEATH <i>3/11/67 7 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE <i>Md.</i> B. COUNTY | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | D. STREET ADDRESS (If rural, give location) <i>21-02</i> | | | |
| 100 1206 W. Cross St. | | | | 1206 W. Cross St. | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>8/20/1905</i> | 9. AGE (In years last birthday) <i>61</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> |
| 13. FATHER'S NAME <i>Charles Marville</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Gertrude Heiback</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Mrs. Gertrude Marville 1139 Carroll St.</i> | | |
| 18. I <i>170X</i> I | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) DUE TO <i>Carcinoma of Breast</i> | | <i>4 years</i> | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (B) DUE TO | | | |
| ANTECEDENT CAUSES | | | | (C) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>May 7 1966</i> to <i>Mar 11 1967</i> , that (I) (we) last saw the deceased alive on <i>Mar 11 1967</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Harry F. Kates</i> M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>3-18-67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>HARRY F. KATES</i> M.D. | | | | 23D. ADDRESS <i>517 Scott St. Baltimore Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>3/15/67</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>London Park Cem.</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 14 1967</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>John J. Cowan & Son Inc.</i> | | ADDRESS <i>23, Md.</i> | |



BIRTH NO.

M.E. CASE NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED
(Type or Print)

MARGARET T. SHELDON

2. DATE AND HOUR PRONOUNCED DEAD

March 11, 1967 10:00 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

43 South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

404 E. Randall Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

October 13, 1966

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

XX 5

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES A. SHELDON JR.

14. MOTHER'S MAIDEN NAME

Margaret Bowen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

NONE

17. INFORMANT

ADDRESS

JAMES A. SHELDON JR. 404 E. RANDALL STREET

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Subendocardial Fibroelastosis.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/12/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

BURIAL

3/14/67

GLEN HAVEN CEMETERY

GLEN BURNIE, MARYLAND

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 14 1967

Robert E. Farber

McCULLY F.H.

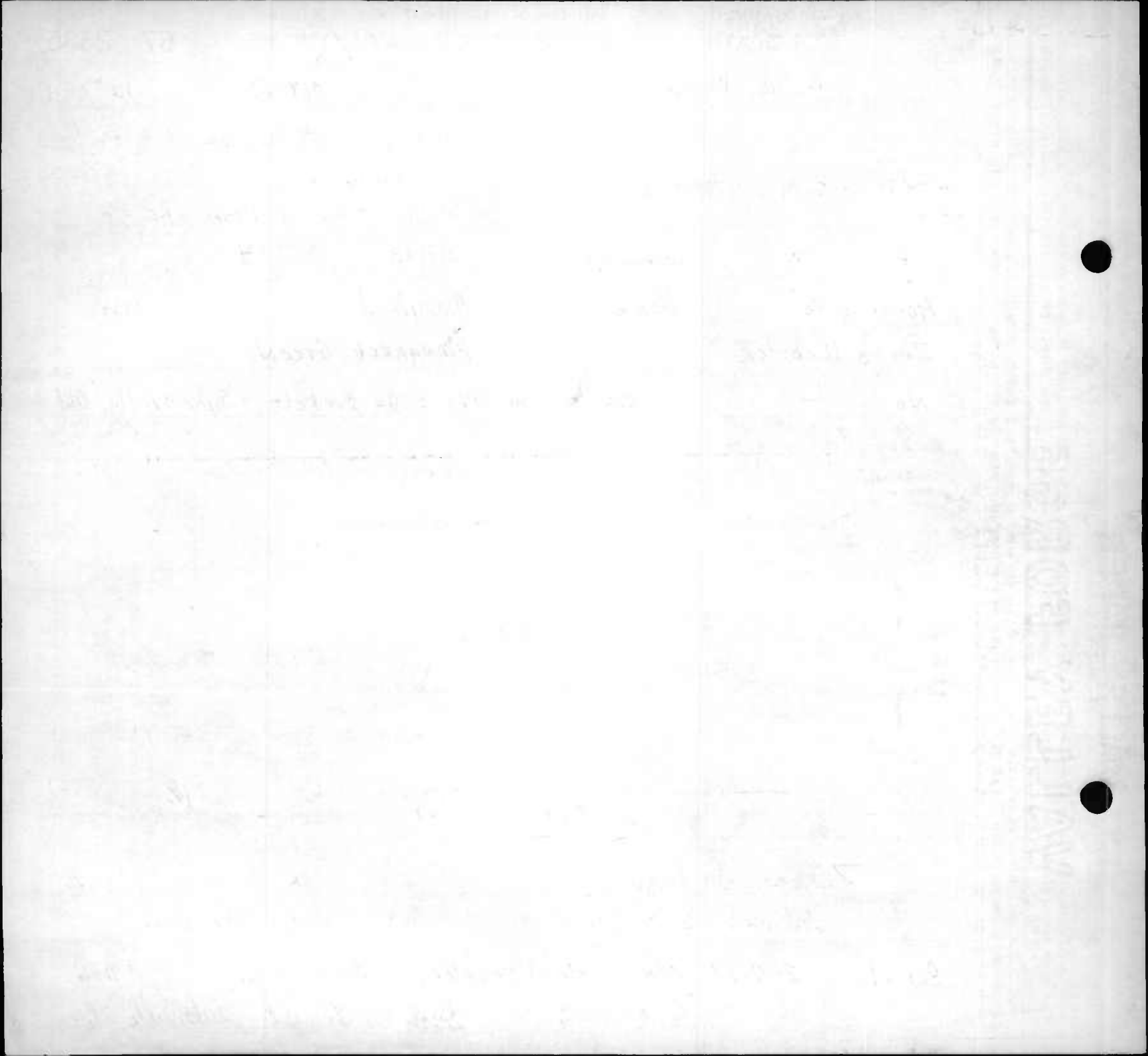
130 E. FORT AVE

WILLY PAPER
FORGERS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 67 2485 | |
|---|---------------------|--|--|--|--|---|--|--|--|--|--|
| BIRTH NO. 67 2485 | | CERTIFICATE OF DEATH | | | | | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Alice Lynch | | | | 2. DATE AND HOUR OF DEATH 3/9/67 12⁴⁰ A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY Baltimore Carroll | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Washington 56-00 | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) Seiggs Boarding Home, Rt #6 | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 3/8/83 | | 9. AGE (In years last birthday) 84 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Jacob Webster | | | | | | 14. MOTHER'S MAIDEN NAME MARGARET GREEN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 212-16-2244 | | 17. INFORMANT ADDRESS Mrs. Elva Pickett - Sykesville, Md. | | | | | |
| 18. 464X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II ASCOD | | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Thrombophlebitis | | | | | |
| | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 19A. DATE OF OPERATION D | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/4 19 67 to 3/9 19 67 , that (I) (we) last saw the deceased alive on 3/7 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Zalman S. Agus | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 3/8/67 | | |
| 23C. PHYSICIAN'S NAME (Type) ZALMAN S. AGUS | | | | | | 23D. ADDRESS University Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3-11-67 | | 24C. NAME OF CEMETERY or CREMATORY Old OAKland Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Sykesville, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967 | | | | 25B. NAME OF REGISTRAR Robert E. Fisher | | | | 25C. FUNERAL DIRECTOR ADDRESS Harry W. Haight Sykesville, Md. | | | |



BIRTH NO. **67 2486** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **67 2486**

M.E. CASE NO.

| | | | |
|---|-------------------------|---|--|
| 1. NAME OF DECEASED (Type or Print) WILLIAM RODRIGUES <i>Rodrigues</i> | | 2. DATE AND HOUR PRONOUNCED DEAD March 10, 1967 8:55 A. <i>M.</i> | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 St. Agnes Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Balto Co C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 53-00 D. STREET ADDRESS (If rural, give location) 2926 Vermont Avenue | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Jan. 12, 1917 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Equip. Operator | | 10B. KIND OF BUSINESS OR INDUSTRY Construction Co. | 9. AGE (In years last birthday) 50 |
| 11. BIRTHPLACE (State or foreign country) Portugal | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Jose Rodrigues | | 14. MOTHER'S MAIDEN NAME Nazare DasNeves | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes 1943- 1944 | | 16. SOCIAL SECURITY NO. 036-16-9183 | |
| 17. INFORMANT Mrs. Clementina Rodrigues | | ADDRESS 2926 Vermont Ave. | |

| | | | |
|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pneumonia complicating multiple traumatic injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. E 812.1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| (A) DUE TO | | | |
| (B) DUE TO | | | |
| (C) DUE TO | | | |

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 19A. DATE OF OPERATION 2-24-67 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Vermont and Magnolia Avenue 53-00 | | | |
| 21D. TIME OF INJURY (APPROX.) 2-24-67 8:30 P. | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Pedestrian struck by auto | | | |

| | | | |
|---|--|--|--|
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Charles S. Springate | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Charles S. Springate, M.D. | | DATE SIGNED March 10, 1967 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE March 13, 1967 | |
| 23C. NAME of CEMETERY or CREMATORY Holy Cross Cem. | | 23D. LOCATION (City, town, or county) (State) Balto. Md. | |

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 24A. DATE REC'D BY HEALTH DEPT. MAR 14 1967 | | 24B. NAME OF REGISTRAR P. O. E. Johnson | | 24C. FUNERAL DIRECTOR G. Truman Schwab | | ADDRESS 3512 Frederick Ave. Balto. Md. | |
|---|--|---|--|--|--|--|--|

CONFIDENTIAL

CONFIDENTIAL

48-35-401B

C-512 67 / 2487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

67 2487

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Leroy ~~444/11/67~~ Leroy Combs

2. DATE AND HOUR OF DEATH

3-11-67

12:25 A

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

COUNTY

(SAINT MARY'S)

68-00

D. STREET ADDRESS (If rural, give location)

RIDGELL REST HOME- SCOTLAND,

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

SEPERATED

8. DATE OF BIRTH

12-31-99

9. AGE (In years
last birthday)

67

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

WILL COMBS, William

14. MOTHER'S MAIDEN NAME

COURTNEY, Idell

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or doles of service)

Yes

WW 2

16. SOCIAL
SECURITY NO.

219-16-757B

17. INFORMANT

#21224

ADDRESS

RECORDS*BCH-4940 EASTERN AVENUE

18.

147X1

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, oshtenio, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

1 year

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-22 19 66 to 3-11 19 67,
that (I) (we) last saw the deceased alive on 3-10-67 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David J. Mishelovich

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

3-11-67

23C. PHYSICIAN'S
NAME (Type)

DR. DAVID J. MISHLOVICH

M.D.

23D. ADDRESS

#21224

BCH-4940 EASTERN AVENUE, BALTIMORE, MD.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

3/14/67

24C. NAME OF CEMETERY or CREMATORY

St. Michaels Cemetery

24D. LOCATION

Ridge,

St. Mary's, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

W. Clarke Mattingley Leonardtown, Maryland

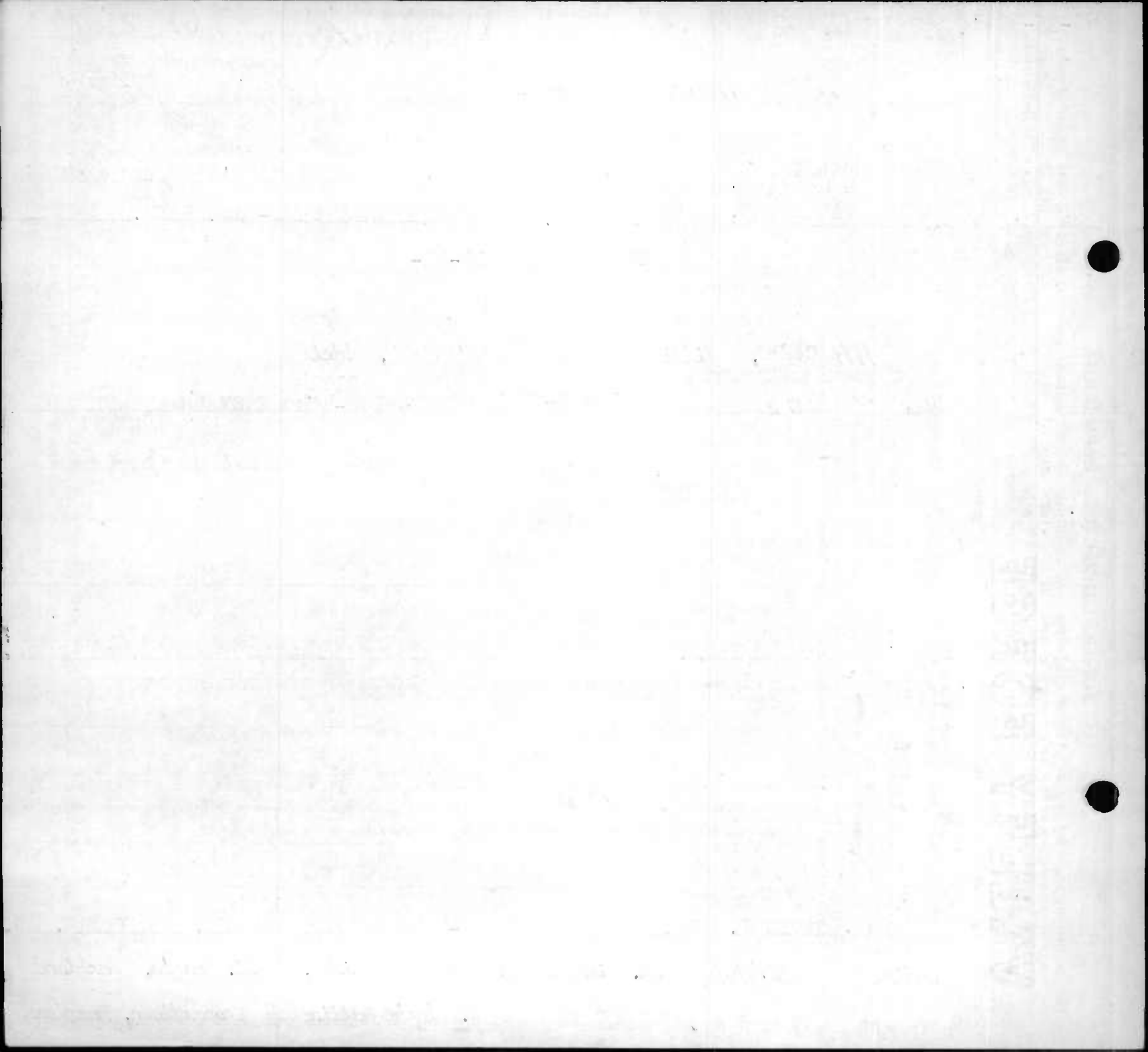
VS 150-REV

MAR 14 1967

D. B. E. Taylor

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 67 2488 | |
|---|---------------------|--|------------------------------------|--|---|
| BIRTH NO. 67 2488 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Heister hagen Catherine</i> | | 2. DATE AND HOUR OF DEATH <i>9:45 3/10/67 9:45 P</i> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Mayland Gen Hosp</i> | | A. STATE <i>Ba</i> B. COUNTY <i>Ba</i> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Ba</i> <i>53-00</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>1913 Stanhope Rd</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M</i> | 8. DATE OF BIRTH <i>10/5/17</i> | 9. AGE (In years last birthday) <i>49</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Assistant. Beth Star Ba</i> | | 11. BIRTHPLACE (State or foreign country) <i>Ba</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>Freiberg</i> | | 14. MOTHER'S MAIDEN NAME <i>EMMA RATHGEBER</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>220-03-8371</i> | | 17. INFORMANT <i>Chart</i> | |
| 18. <i>199.2.1</i> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Uremia</i> | | | |
| ANTECEDENT CAUSES | | (B) <i>Bilateral lobe renal atrophy</i> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) <i>Pyo-hydronephrosis metastatic carcinoma</i> | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>3/7/67</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ureteral atrophy</i> | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1/21</i> 19 <i>67</i> to <i>3/10</i> 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>3/10</i> 19 <i>67</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Daniel C. Wilkerson</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>3/10/67</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Daniel C. Wilkerson</i> | | 23D. ADDRESS <i>421 Regester Ave.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>3/14/67</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>OAK LAWN</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>BALTO MD</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>MAR 14 1967</i> | | | |
| 25B. NAME OF REGISTRAR <i>R. E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>J. D. Connolly Sons - 300 Mac</i> | | | |
| 25D. ADDRESS (21) | | | | | |

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Handwritten text in the upper middle section, including some numbers and possibly a date.

Handwritten text in the middle section, appearing to be a list or series of notes.

Handwritten text in the lower middle section, possibly a continuation of the list or notes.

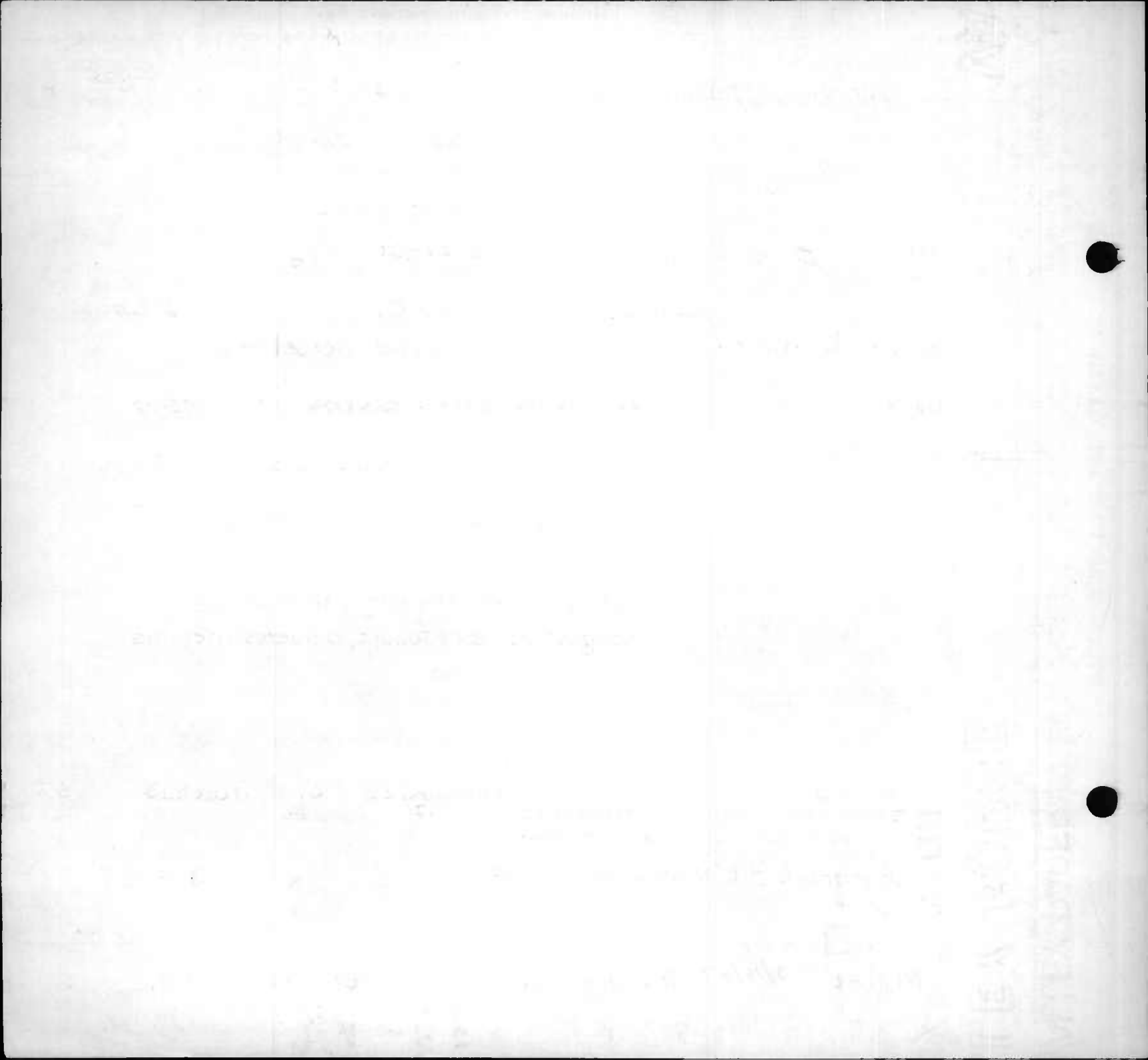
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Handwritten text at the bottom of the page, possibly a footer or concluding remarks.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

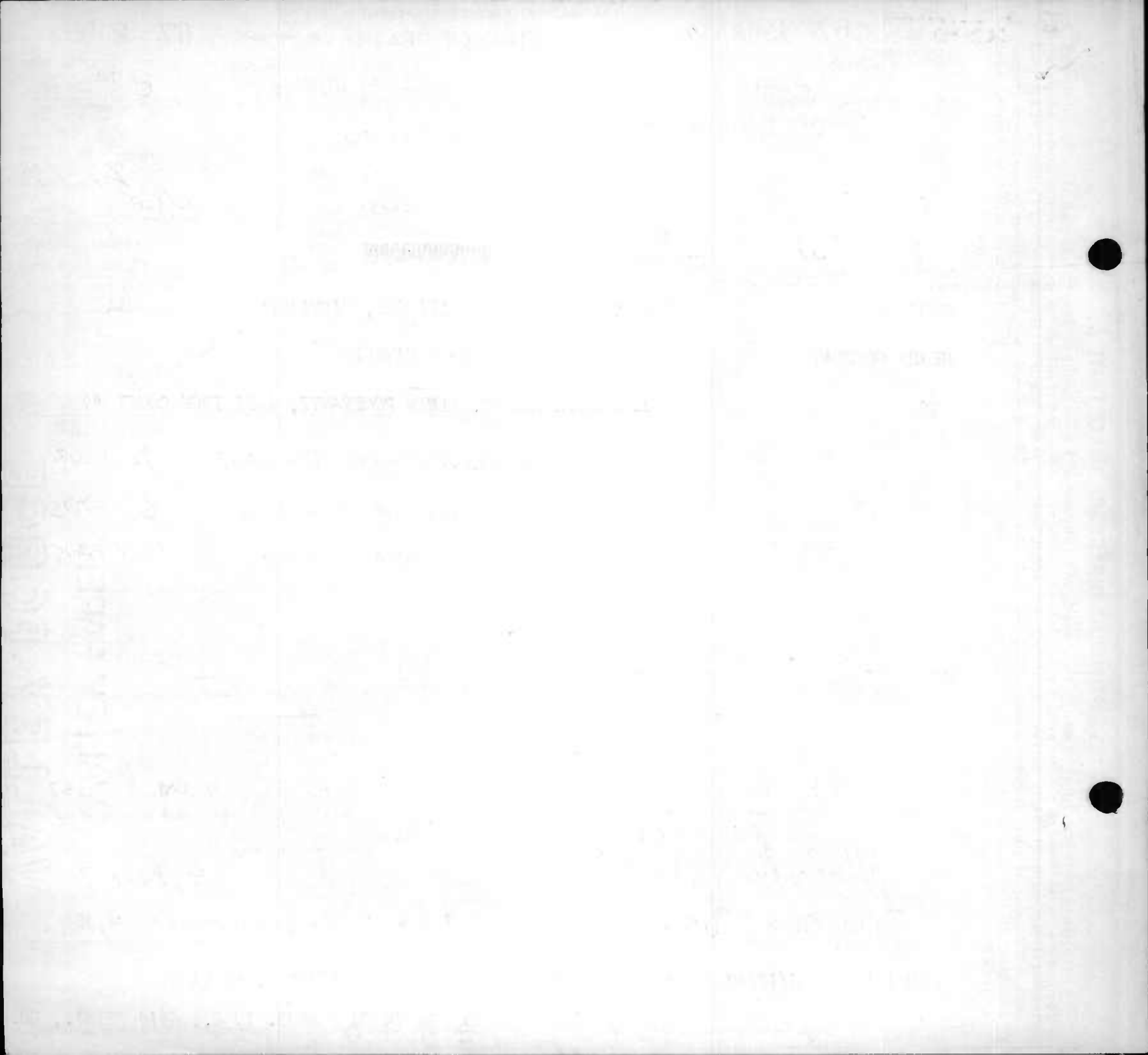
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---|---------|--|---|---------------------------------|--|
| BIRTH NO. | | 67 2489 | | 67 2489 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| Mr. Vivian S. Dameron | | | 3-13-67 800 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| Mercy Hospital | | | MD. BALTO. Co. | | |
| 37 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | Baltimore 53-00 | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 46 Blister St | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| M | W | married | 2-27-01 | 66 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| | | | M. C. | | USA |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Ratle Dameron | | | Minnie Howelles | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT | | ADDRESS |
| UNIK | | 224-05-4265 | GENEVA DAMERON | | ABOVE |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) cerebral thrombosis | | 3 wks |
| ANTECEDENT CAUSES | | | (B) generalized atherosclerosis | | ? |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | coronary insufficiency, intractable congestive heart failure, diabetes mellitus | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | | no | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| | | | | | |
| 22. I certify that (this hospital) attended the deceased from February 23, 1967 to March 13, 1967, that (we) last saw the deceased alive on March 13, 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| Raymond E. Knowles, Jr. M.D. | | | 3-13-67 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| | | | M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) |
| BURIAL | | 3/16/67 | BEL AIR MEM. | | BEL AIR MD. |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| MAR 14 1967 | | Robert E. Taylor | | 244 Gwyneth Lane 300 Mose | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

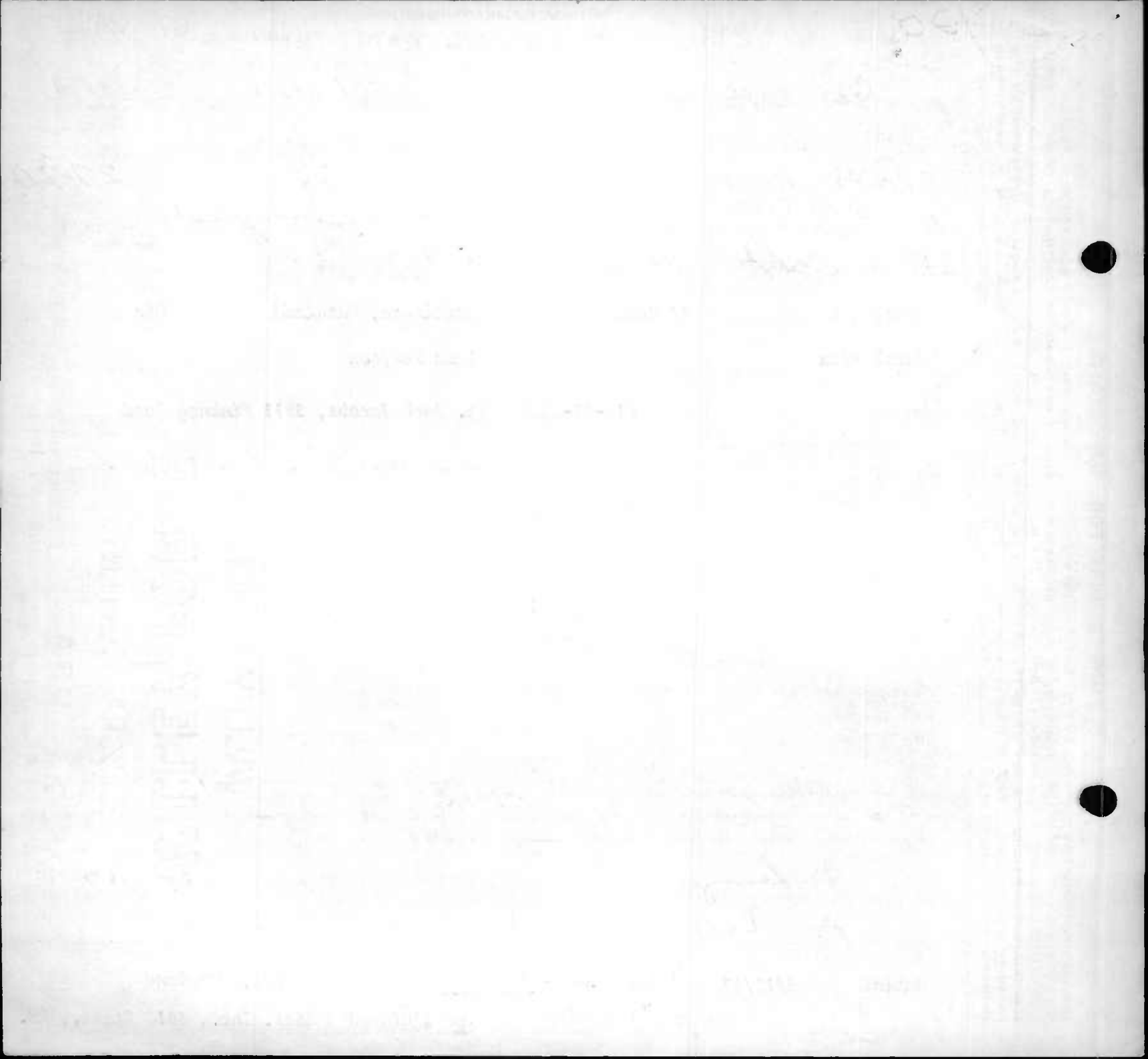
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|--|-----------|---|--|---|---|------------------------------|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 67 2480 | | | | | |
| BIRTH NO. 67 2480 | | M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) LENA GOODMAN | | | 2. DATE AND HOUR OF DEATH 9 MAR 67 8 45 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL, BALTO, MD | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3033 W. GARRISON Ave. 27-17 | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) DIVORCED | | 8. DATE OF BIRTH [REDACTED] | 9. AGE (In years last birthday) 68 | 11. Under 1 Yr. Months: Days | | 12. Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME HENRY GOODMAN | | | | | 14. MOTHER'S MAIDEN NAME ANNA MANEKIN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. UNKNOWN | | 17. INFORMANT ADDRESS MR. ALVIN POMERANTZ, 6602 TROY COURT #9 | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 294X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CAUSE OF DEATH (A) CEREBROVASCULAR ACCIDENT DUE TO (B) MYELOID METAPLASIA DUE TO (C) POLYCYTHEMIA UERA DUE TO INTERVAL BETWEEN ONSET AND DEATH 1/2 HOUR 6 YEARS 15 YEARS | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) + | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 65 to 9 MAR 19 67, that (I) (we) last saw the deceased alive on 9 MAR 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Malcolm S. Druskin M.D. | | | | | 23B. DATE SIGNED 9 MAR 67 | | | 23C. PHYSICIAN'S NAME (Type) MALCOLM S. DRUSKIN M.D. | | |
| 23D. ADDRESS 2217 SOUTH ROAD, BALTIMORE 9, MD. | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 3/12/67 | | 24C. NAME OF CEMETERY or CREMATORY BNAI ISRAEL | | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967 | | 25B. NAME OF REGISTRAR [Signature] | | | 25C. FUNERAL DIRECTOR ADDRESS SQL LEVINSON & BROS. IN C., 6010 REIST., RD. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|---|----------------------|--|---------------------------------|---|--|
| S-1420 | | 67 2491 | | 67 2491 | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>GERTRUDE SELIS</u> | | | | 3/10/67 6:30 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL OF BALTIMORE, INC.</u> | | | | A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>3911 Pinkney Rd.</u> | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>WIDOWED</u> | 8. DATE OF BIRTH <u>11-4-98</u> | 9. AGE (In years last birthday) <u>68</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>Jacob Flax</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Lena Wolfson</u> | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>218-03-3866</u> | | | | 17. INFORMANT ADDRESS <u>Mr. Jack Jacobs, 3911 Pinkney Road</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u> | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes Mellitus</u> | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>2/28/67</u> to <u>3/10</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>A. Levy</u> | | | | 23B. DATE SIGNED <u>3/10/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>A. LEVY</u> | | | | 23D. ADDRESS <u>SINAI HOSPITAL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3/12/67</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Anshe Eminent-Aitz Chaim</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u> | | (State) <u></u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1967</u> | |
| 25B. NAME OF REGISTRAR <u>Charles J. Jacobs</u> | | 25C. FUNERAL DIRECTOR <u>Spel Levinson & Bros. Inc.</u> | | ADDRESS <u>6010 Reist., Rd.</u> | |

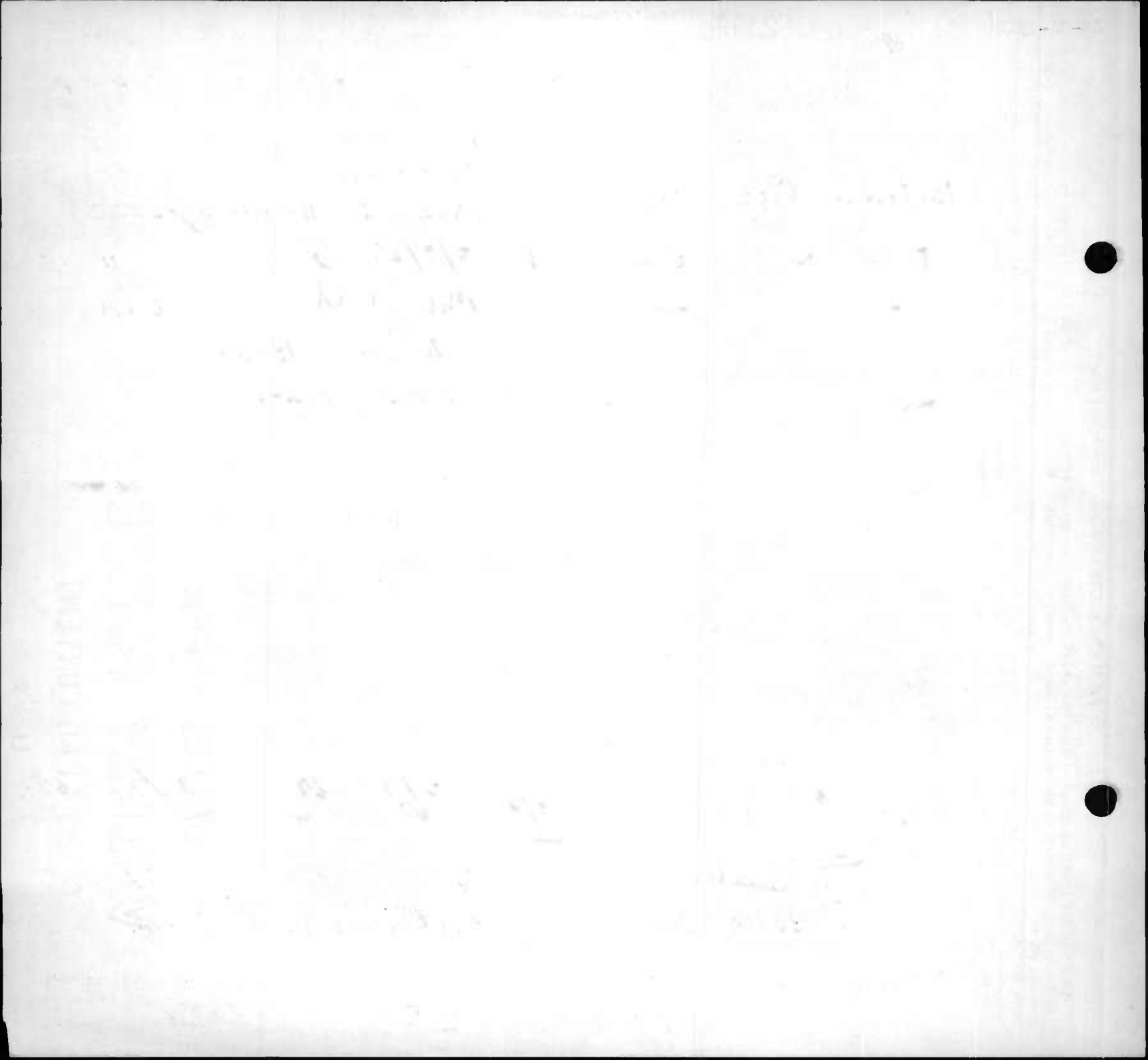


48-84-73TN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

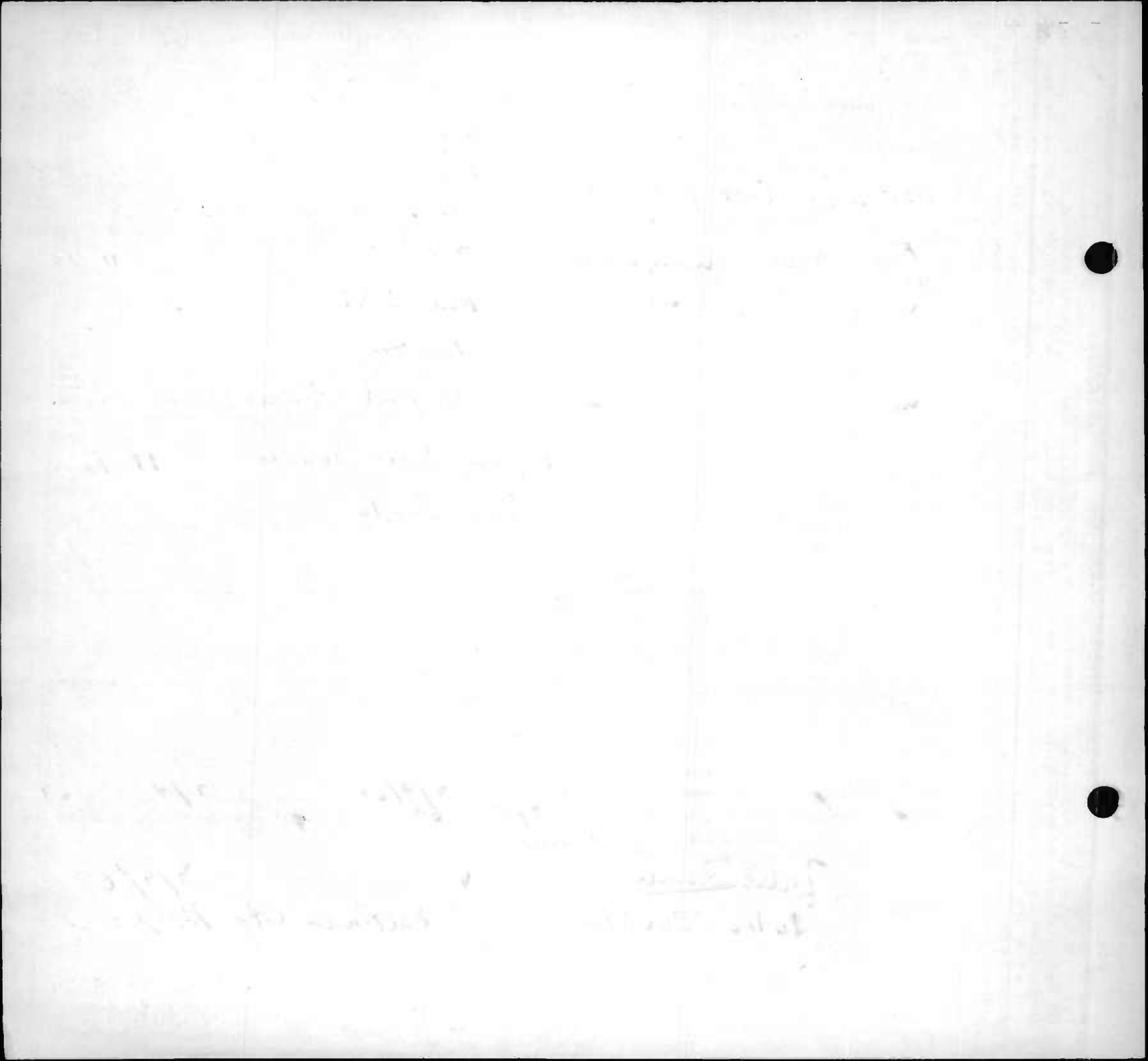
| | | | | | |
|---|---------------|---|-------------------------|---|--|
| J-52067 2492 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2492 | |
| BIRTH NO. 67-1648 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Jones baby girl Alice | | 2. DATE AND HOUR OF DEATH 3/9/67 4 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1832 N. Broadway - 21213 | | 8-05 | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED | 8. DATE OF BIRTH 3/9/67 | 9. AGE (In years last birthday) 2 | 10. IF Under 1 Yr. Months: Days: 11 15 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME Alice Jones | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT BEH: RECORDS 1940 EASTERN AVENUE | |
| 18. 773.5T DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Respiratory distress syndrome DUE TO Prematurity (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 11 hours | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/9 1967 to 3/9 1967, that (I) (we) last saw the deceased alive on 3/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/9/67 | |
| 23C. PHYSICIAN'S NAME (Type) DR. JULIO ZAVALA | | 23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 3-10-67 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals Baltimore, Maryland 21224 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| VS 150-REV. 1/1/67 MAR 14 1967 2 HOSPITAL DISPOSAL | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2493 | | | | Baltimore City Health Department | | Registered No. 67 2493 | |
|---|---------------|--|-------------------------|--|----------------------------|---|-------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Makias baby Girl MATTIE | | | | 2. DATE AND HOUR OF DEATH 3/9/67 12 noon Mr. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospital Baltimore 21224, Maryland | | | | A. STATE Md. | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1000 Bethune Road - 25-32 | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married | 8. DATE OF BIRTH 3/9/67 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | 11 15 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10B. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (State or foreign country) Md. U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME Mattie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT BCH Hospital Records | | ADDRESS #21224 4940 Eastern Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH (A) Respiratory Distress Syndrome (B) Prematurity (C) | | INTERVAL BETWEEN ONSET AND DEATH 17 hours | |
| 19. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/9/67 19 to 3/9 1967, that (I) (we) last saw the deceased alive on 3/9 1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Julio Zavala | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 3/9/67 | |
| 23C. PHYSICIAN'S NAME (Type) Julio Zavala | | | | 23D. ADDRESS Baltimore City Hospital, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 3-10-67 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospital | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224 | |
| 25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967 | | 25B. NAME OF REGISTRAR Robert E. Staley | | 25C. FUNERAL DIRECTOR ADDRESS | | HOSPITAL DISPOSAL | |



APPROVED & RELEASED BY MEDICAL EXAMINER F.X. CARMODY MD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--|------------------|---|------------------------------|--|---|
| 67 2494 | | CERTIFICATE OF DEATH | | 67 2494 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Greutzner, William Henry | | 3.05 AM. March 13, 1967 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE md | | B. COUNTY | |
| The Union Memorial Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | | 102 E 22nd Street | |
| 5. SEX (F) MALE | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 08-28-88 | 9. AGE (In years last birthday) 78 | 10. AGE (In years last birthday) 78 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired | | Merchant Seaman | | Md - Balto. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Edward William Greutzner | | Unknown (Henrietta - ?) | | American | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| Yes W W I | | 318-09-4968 | | MARGARET FRITZE | |
| | | | | Mrs. Catherine Greutzner | |
| | | | | Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| E903.1 | | (A) Branch pneumonia | | 6 days | |
| ANTECEDENT CAUSES | | (B) CEREBROCRANIAL INJURIES | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. | | (C) Cerebral Contusion, subdural hemorrhage & skull fracture | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 102 E. 22nd St., BALTIMORE | |
| 3-7-67 6:10 PM | | | | 12-04 | |
| 22. I certify that (I) (this hospital) attended the deceased from | | March 7, 1967 | | 19 to 3.05 AM March 13, 1967. | |
| that (I) (we) last saw the deceased alive on | | 3.05 AM March 13, 1967 | | and that in (my) (our) opinion death occurred on the date | |
| | | | | and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Sang Won Song | | | | March 13, 1967 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| SANG WON SONG, | | THE UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | 3/15/67 | | Balto. NATIONAL | |
| | | | | Balto. md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| MAR 14 1967 | | R. E. Taylor, MD | | Stewart & Mowen Co. - 108 W. North Av. | |
| | | | | BALTO - 21201 | |

17

Handwritten text, possibly a signature or name.

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Handwritten text, possibly a name.

182

182

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2495 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2495 | |
|---|-------------------------|--|-----------------------------------|--|----------------------------|--|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Hill, Herbert</u> | | | | 2. DATE AND HOUR OF DEATH <u>3/10/67</u> <u>12 45</u> A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital of Baltimore</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | D. STREET ADDRESS (If rural, give location) <u>3435 Park Heights Ave.</u> | | | |
| 5. SEX <u>male</u> | 6. RACE <u>negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u> | 8. DATE OF BIRTH <u>6/3/94</u> | 9. AGE (In years last birthday) <u>72</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>214123543</u> | | 17. INFORMANT <u>Livinia Hill</u> | | ADDRESS <u>3435 Park Heights Ave.</u> | |
| 18. <u>443X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <u>Cerebrovascular Accident</u> <u>7 days</u> DUE TO (B) <u>Hypertensive Cardio & Cerebrovascular disease</u> <u>years</u> DUE TO (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Bilateral Bronchopneumonia</u> <u>3 days</u> | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/3</u> 19 <u>67</u> to <u>3/10</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> 19 <u>67</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Erwin H. Hesselberg</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>3/10/67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Erwin H. Hesselberg</u> | | | | 23D. ADDRESS <u>Sinai Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>3-14-67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1967</u> | | 25B. NAME OF REGISTRAR <u>Erwin H. Hesselberg</u> | | 25C. FUNERAL DIRECTOR <u>Kelson Funeral Home</u> | | | |
| ADDRESS <u>1348 Calhoun St.</u> | | | | | | | |

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67 2496

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2496

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS F. DUNAWAY

2. DATE AND HOUR PRONOUNCED DEAD

March 10, 1967 11:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

911 Bertuna Road

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

Aug. 26, 45

9. AGE (In years
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Thomas Dunaway

14. MOTHER'S MAIDEN NAME

Roberta Ferguson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL
SECURITY NO.

213462756

17. INFORMANT

ADDRESS

Thomas Dunaway 911 Bethune Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Gunshot Wound of Abdomen.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Millington Lane and Lehman Street

21D. TIME OF INJURY (APPROX.)
(Month) (Day) (Year) (Hour)

3 10 '67 P

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Shot during altercation.

20-05

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Petty

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

3/11/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-16-67

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

Balto.

(City, town, or county)

Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

MAR 14 1967

Kelson Funeral Home 1348 Calhoun St.

N 87919670002504

VALLEY PARK
VALLEY FORCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>67 2497</u> | |
|--|---------------------|---|-------------------------------------|---|---|
| BIRTH NO. <u>67 2497</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Lucy Copper</u> | | 2. DATE AND HOUR OF DEATH <u>3-10-67</u> <u>7:25</u> A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> <u>44</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>2447 BARCLAY ST.</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <u>11-11-82</u> | 9. AGE (In years last birthday) <u>84</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) <u>GREENVILLE NO. CAROLINA</u> | |
| 13. FATHER'S NAME <u>STEVEN FLOYD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT <u>ANNIE WARD</u> <u>1625 E. 8th St. Balto.</u> | |
| 18. <u>422.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ANTCEDENT CAUSES</u> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> (B) <u>MALNUTRITION</u> (C) — | | INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that <u>the</u> (this hospital) attended the deceased from <u>Feb 21</u> 19 <u>67</u> to <u>MARCH 10</u> 19 <u>67</u> , that <u>he</u> (we) last saw the deceased alive on <u>MARCH 10</u> 19 <u>67</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>we</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Judith D. Gardner</u> | | | | 23B. DATE SIGNED <u>3-10-67</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>JUDITH D. GARDNER</u> | | | | 23D. ADDRESS <u>Union Memorial Hospital</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>3-13-67</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Phillipi CEMETERY</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>GREENVILLE, NORTH CAROLINA</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>MAR 14 1967</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Fairburn</u> | | 25C. FUNERAL DIRECTOR <u>HESSON FUNERAL HOME 1848 CALHOUN ST.</u> | | | |

22-55000-100000

BIRTH NO.

67 2498

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

67 2498

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS HERBERT

2. DATE AND HOUR PRONOUNCED DEAD

March 12, 1967 9:30 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 642 Pitcher Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

642 Pitcher Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

2-8-40

9. AGE (in years
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Herbert Thomas

14. MOTHER'S MAIDEN NAME

Mary Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

219329430

17. INFORMANT

ADDRESS

Lillie Mae Thomas 1115 Carson Court

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Fatty Liver.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3/12/67

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

3-16-67

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 14 1967

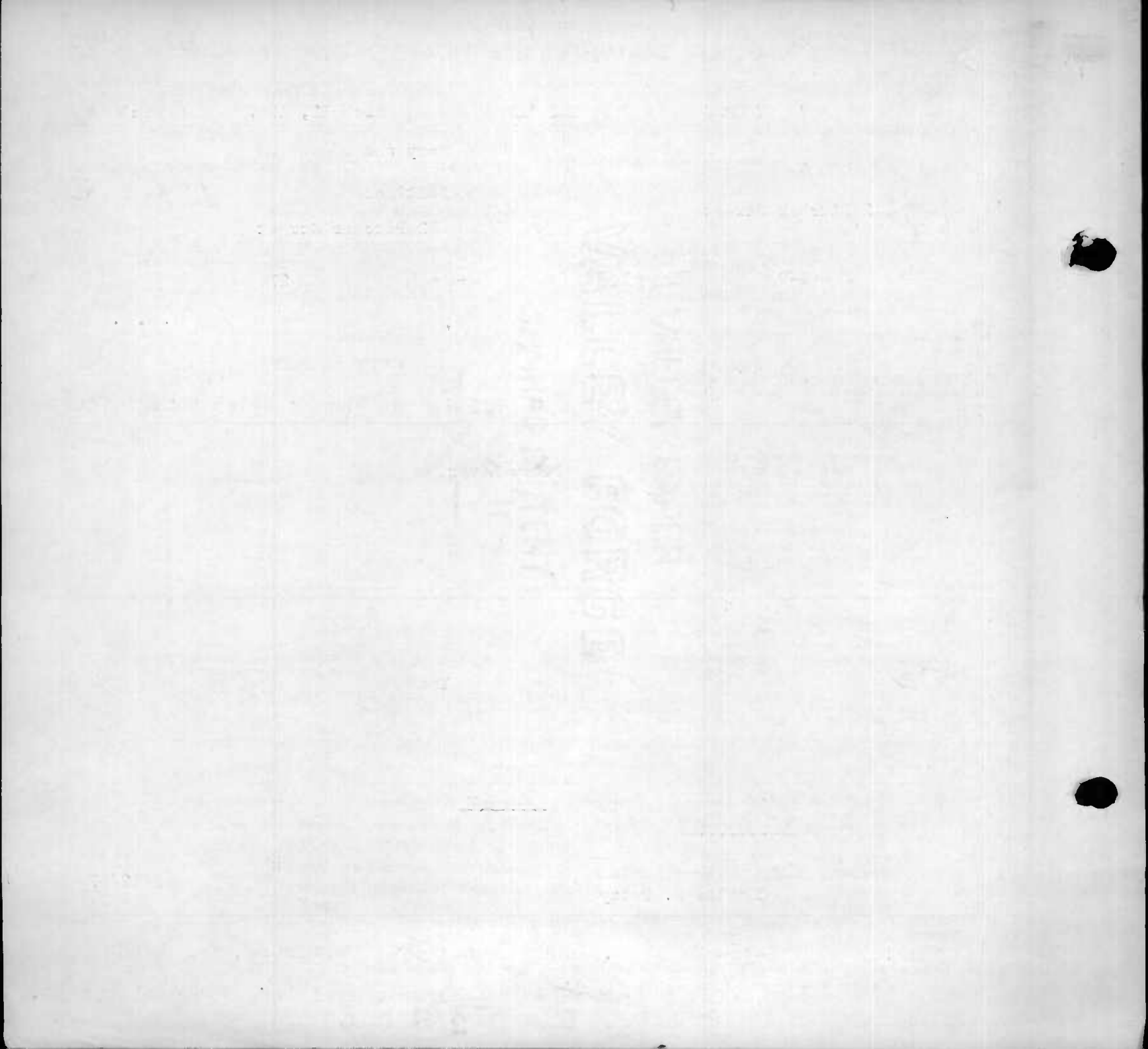
24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

Kelson Funeral Home 1348 Calhoun St.

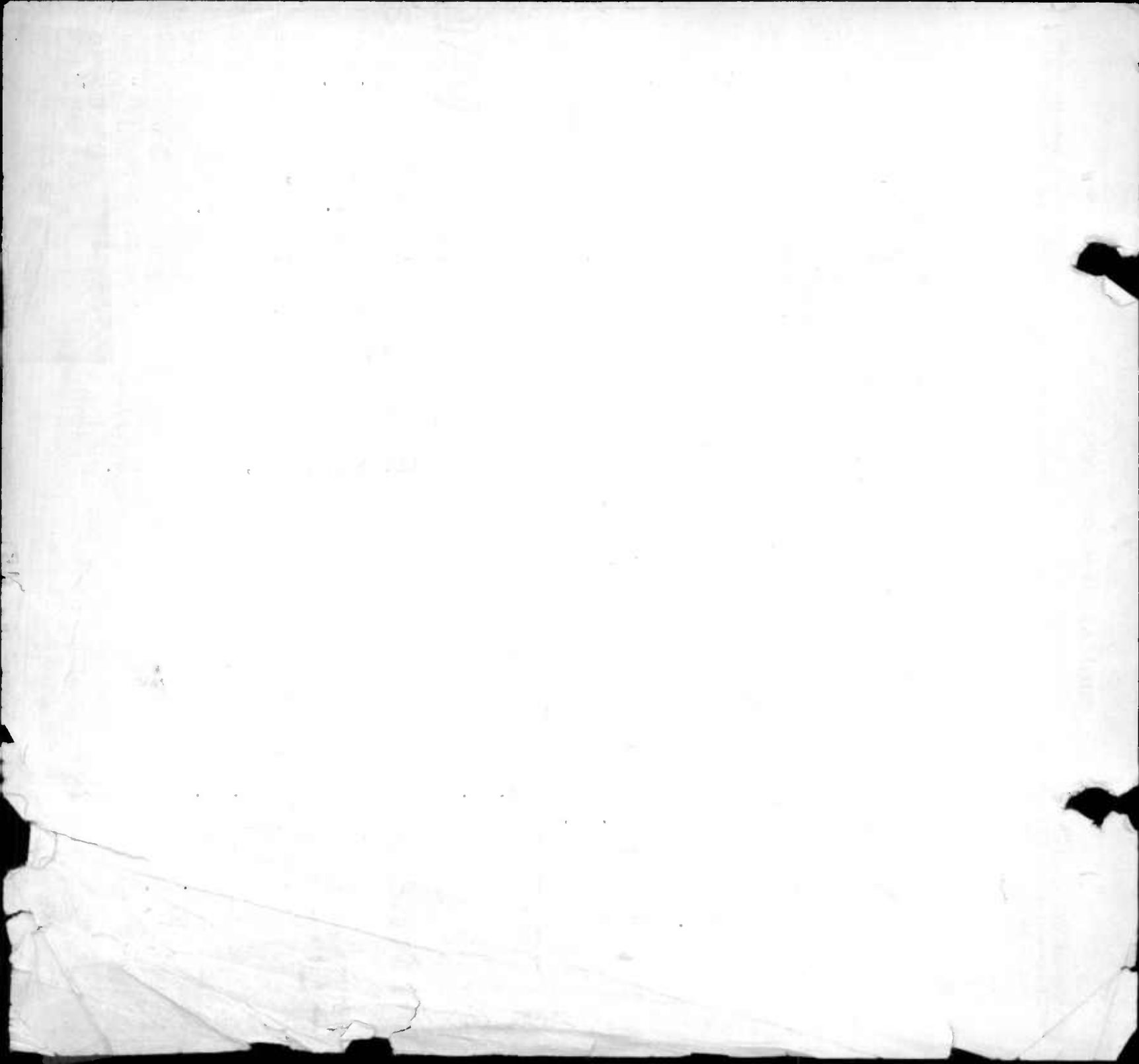
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 67 2499 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 67 2499 | |
|---|-------------------------|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) David Carter | | 2. DATE AND HOUR OF DEATH 3.12.67 9:51AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 2 D. STREET ADDRESS (If rural, give location) 807 E. CHASE ST. | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH 12-17-1907 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Savannah, Ga. | |
| 13. FATHER'S NAME GEORGE CARTER | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Margella Carter ADDRESS Lane |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Metastatic sarcoma, | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | INTERVAL BETWEEN ONSET AND DEATH 3 mos. | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 3.25.67 19 to 3.12.67 19, that (I) (we) last saw the deceased alive on 3.12.67 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert M. Winslow M.D. | | | | 23B. DATE SIGNED 3.12.67 | |
| 23C. PHYSICIAN'S NAME (Type) Robert M. Winslow M.D. | | | 23D. ADDRESS Hohns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 3-9-67 | | 24C. NAME OF CEMETERY or CREMATORY Not known | |
| 24D. LOCATION (City, town, or county) (State) Balto Md | | 25A. DATE REC'D BY HEALTH DEPT. MAR 14 1967 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fink | | 25C. FUNERAL DIRECTOR Charles W. Johnson ADDRESS 1000 North Ave | | | |



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A-140

67 2500

BALTIMORE CITY HEALTH DEPARTMENT

67 2500

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

RICHARDDEAN A. ABLE

2. DATE AND HOUR PRONOUNCED DEAD

March 9, 1967 5:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

40
99 St. Agnes Hospital

(DOA)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland 5037 Orville Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5037 Orville Avenue

5

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Oct. 26, 1913

9. AGE (In years
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Candy Packer

10B. KIND OF BUSINESS OR INDUSTRY

Mary Sue Candy Co. Baltimore Md.

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Arthur Burdette

14. MOTHER'S MAIDEN NAME

Virginia Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

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16. SOCIAL
SECURITY NO.

216-09-7150

17. INFORMANT

ADDRESS

Mrs. Sandra Trosclair, 5037 Orville Ave. 5

18. 422.21

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Interstitial myocardial fibrosis,
etiology undetermined

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

March 10, 1967

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Mar. 13, 1967

23C. NAME of CEMETERY or CREMATORY

Baltimore Cem.

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

MAR 14 1967

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Philip's Herwig Sons

ADDRESS

31

2024 Orleans Street

